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U.S. Administration on Aging

PART A - Accelerating Integrated, Evidence-Based, and Sustainable Service Systems for Older Adults, Individuals with Disabilities and Family Caregivers

PART B – Creating Dementia Capable, Sustainable Service Systems For Persons With Dementia And Their Family Caregivers

Program Announcement and Grant Application Instructions

U.S. Administration on Aging
FY 2011

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INTRODUCTION AND OVERVIEW

The Administration on Aging (AoA) will award up to $14 million in competitive grants to State Units on Aging through this Program Announcement**.**

The Program Announcement combines funding opportunities for states from the Older Americans Act Title IV and the Public Health Services Act Sec. 398. There are two parts to this Program Announcement: **Part A** - "*Accelerating Integrated, Evidence-Based, and Sustainable Service Systems for Older Adults, Individuals with Disabilities and Family Caregivers"* and **Part B** – "*Creating Dementia Capable, Sustainable Service Systems For Persons With Dementia And Their Family Caregivers*".

AoA is seeking to work with applicants to develop and operate integrated long-term service and support systems that are dementia capable; therefore, applicants are encouraged to apply for both Parts A and B of this Program Announcement. This Program Announcement contains a detailed description of Part A and Part B which will be posted twice on http://www.grants.gov. Applicants can review one Program Announcement for both priorities and instructions, however to apply for both parts an applicant must submit separate applications under the separate Program Announcement titles.

The goal of this Program Announcement is to ensure that older adults, individuals with disabilities and family caregivers have clear and ready access to a sustainable, integrated system that offers a comprehensive set of high quality, evidence-based services that can help them remain independent and healthy in the community.

To achieve its goal, AoA will award fully funded 3-year cooperative agreements to successful applicants that agree to implement, and sustain a statewide, integrated service system on two levels:

↕ **Between** the state and local communities to implement, and sustain a statewide system.

↔ **Across** health and human service systems to streamline and facilitate enrollment in a comprehensive array of high quality services and supports.

An integrated, sustainable service system entails meeting two key objectives across these two levels:

Objective 1. Coordinate the integration of a statewide set of programs that includes a Single Entry Point/No Wrong Door (SEP/NWD) access for individuals.

Objective 2. Ensure access to a comprehensive, sustainable set of high quality services relevant to the population residing in the state's service area.

Successful applications must thoroughly describe the applicants' current system related to the two objectives and their core components as described in Parts A and B.

The national consensus is that our home and community-based service system must be more responsive to the unique needs of individuals by providing better services and ensuring the effective use of program funds. AoA and its partners, including but not limited to the Centers for Disease Control (CDC); Centers for Medicare & Medicaid Services (CMS); the Office on Disability (OD), and the Substance Abuse and Mental Health Services Administration (SAMHSA) envision a system that maximizes individuals' health, independence, dignity, choice, and flexibility by providing statewide access to an integrated, comprehensive set of high quality services and supports.

AoA and its partners have implemented a number of innovative health promotion, disease prevention, and community living programs designed to promote development of such a system. These programs include:

Alzheimer's Disease Supportive Services Program, which funds Alzheimer's Evidence-based Caregiver Interventions and Alzheimer's Innovations Grants that accomplish such goals as piloting and translating interventions and reforming long-term services and supports programs to meet the unique needs of persons with the disease and their caregivers.

Caregiver support programs such as the National Family Caregiver Support Program and Lifespan Respite Care that are designed to provide caregivers of older adults and persons with disabilities assistance in carrying out their responsibilities.

Community Living Programs that promote the health and independence of persons with disabilities in the community. These programs encompass Aging and Disability Resource Centers, Options Counseling, Care Transitions, and Veteran-Directed Home and Community-Based Services.

Health Programs that promote the health and well-being of older Americans and persons with disabilities, such as Evidence-based Health Promotion and Disease Prevention Programs, Chronic Disease Self-Management Program, and Older Americans Act Disease Prevention and Health Promotion Services Program (Title III-D).

Descriptions of all of these programs and more can be found at http://www.aoa.gov/AoARoot/AoA_Programs/index.aspx .

In addition to these programs, Medicare, Medicaid, and other Older Americans Act programs provide a web of services and supports to older adults, persons with disabilities and their family caregivers. This Program Announcement is designed to promote statewide access to an integrated, comprehensive set of high quality services and supports that encompasses the full range of services including, to the maximum extent possible, evidence-based interventions that support these populations. Statewide access will be critical to the success of this new program as will creation of a dementia capable system. An integrated, comprehensive system will include a fully functioning single entry point (SEP)/no wrong door (NWD) component that serves as the access point to connect people to needed services.

Please see Attachment G for definitions of terms used in this program announcement.

Funding Opportunities At a Glance

Funding Opportunity	Funding Source	Amount	Purpose	Eligible Applicants	Match Requirements
Part A	Title IV of OAA (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365	Cooperative agreements ranging from $1.2 to $3 million total for the award period (FY11 – FY13). 4 to 7 awards will be fully funded for the 3 year award period.	Develop and operate a sustainable, integrated system that offers a comprehensive set of high quality, evidence-based services that help people remain independent and living in the community	State Units on Aging	Applicant must match at least 5% of the project's total cost with non-Federal resources.
Part B	Sec. 398 of the Public Health Service Act (P.L. 78-410; 42 U.S.C. 280c-3)	Cooperative agreements ranging from $370,000 to $1,000,000 total for the award period (FY11-FY13). 4 to 7 awards will be fully funded for the 3 year award period.	Assure that integrated system is dementia capable and offering evidence-based dementia services and caregiver support programs	State Units on Aging	Applicant must provide a 25% match (cash and/or in-kind) during the first year, 35% during the second year, and 45% during the third and subsequent years of the award period.

FUNDING OPPORTUNITY INFORMATION

Department of Health and Human Services (HHS)

Administration on Aging (AoA)

AoA Center for Policy, Planning, and Evaluation

Funding Opportunity Title:
Part A - "*Accelerating Integrated, Evidence-Based, and Sustainable Service Systems for Older Adults, Individuals with Disabilities and Family Caregivers"*
See page 8.

Announcement Type: Initial

Funding Opportunity Number: HHS-2011-AoA-AA-***1113***

Catalog of Federal Domestic Assistance (CFDA) Number: 93.048 (Part A)

Key Dates: The deadline date for submission of applications is 11:59 p.m., Eastern Time, on July 27, 2011. Please submit a letter of intent noting which Parts of the Program Announcement you plan to apply for under this Funding Opportunity by June 27, 2011. An open information teleconference for applicants of the funding opportunities under this announcement will be held as follows: June 22, 2011 at 3PM EST. The toll-free teleconference phone number will be 888-982-4690 pass code: 41896

Funding Opportunity Title:
Part B – "*Creating Dementia Capable, Sustainable Service Systems For Persons With Dementia And Their Family Caregivers*"
See page 33.

Announcement Type: Initial

Funding Opportunity Number: HHS-2011-AoA-DS-***1114***

Catalog of Federal Domestic Assistance (CFDA) Number: 93.051 (Part B)

Key Dates: The deadline date for submission of applications is 11:59 p.m., Eastern Time, on July 27, 2011. Please submit a letter of intent noting which Parts of the Program Announcement you plan to apply for under this Funding Opportunity by June 27, 2011. An open information teleconference for applicants of the funding opportunities under this announcement will be held as follows: June 22, 2011 at 3PM EST. The toll-free teleconference phone number will be 888-982-4690 pass code 41896

PART A: Accelerating Integrated, Evidence-based, and Sustainable Service Systems for Older Adults, Individuals With Disabilities And Family Caregivers

I. FUNDING OPPORTUNITY DESCRIPTION: PART A

Statutory Authority

The statutory authority for grants under this Program Announcement is contained in Title IV of the Older Americans Act (OAA) (42U.S.C. 3032), as amended by the Older Americans Act Amendments of 2006, P.L. 109-365. (Catalog of Federal Domestic Assistance 93.048, Title IV Discretionary Projects).

II. AWARD INFORMATION: PART A

The Administration on Aging (AoA) will award approximately $9 to 11.5 million in competitive cooperative agreements to State Units on Aging through this initial Funding Opportunity Announcement entitled: ***Accelerating Integrated, Evidence-Based, and Sustainable Service Systems for Older Adults, Individuals with Disabilities and Family Caregivers***. This new funding opportunity will award cooperative agreements to approximately 4 to 7 successful applicants that agree to implement and sustain a statewide, integrated service system as described in this Program Announcement. The funding period is 3 years, with an anticipated start date of September 30, 2011. Cooperative agreement amounts are expected to range from $1.2 to $3 million for each 3 year grant. Grant awards will be fully funded for the 3 year grant period.

A. Funding Opportunity Goal and Objectives: Part A

The overall purpose of Part A of this program announcement is to enable states to develop, implement, and sustain statewide, integrated systems that offer a comprehensive set of high quality, evidence-based services that can help older adults, individuals with disabilities, and family caregivers to remain independent and healthy in the community. Creating a statewide, integrated system involves building upon and integrating existing programs:1) between states and communities, and 2) across health and human service systems. The resulting systems must meet this Program Announcement's two objectives and their core components.

Applicants for Part A of this Announcement are encouraged to apply for Part B of this Announcement. Part B is entitled***, Creating Dementia Capable, Sustainable Service Systems for Persons with Dementia and their Family Caregivers.***

Objective 1: Coordinate the integration of a statewide set of programs that includes a Single Entry Point/No Wrong Door (SEP/NWD) access for individuals.

A statewide system is one in which individuals anywhere in the state have streamlined access to the full array of public and private sector programs and services that promote community living, health and independence. The core components of objective 1 include:

1. **Information, Referral and Access**
2. **Options Counseling and Assistance**
3. **Streamlined Eligibility Determinations for Public Programs and Assistance in Applying for these Programs**
4. **Person-Centered Care Transitions Across Multiple Settings**

These core components are to be integrated through community-wide systems of information, counseling and access, offering a single point of entry for services or a "no wrong door" approach to accessing services. Individuals' access to services is to be seamless, regardless of the programs they use.

In developing and implementing the statewide access system, grantees must build on:

- Existing access points, such as Area Agencies on Aging (AAAs); Aging and Disability Resource Centers (ADRCs); Benefits Enrollment Centers (BECs), Centers for Independent Living (CILs), and State Heath Insurance Assistance Programs (SHIPs).

- Disability capable services/systems. Comprehensive single points of entry, No Wrong Door or other comparable approaches must provide or seamlessly connect persons with disabilities including physical disabilities, intellectual and developmental disabilities, and mental health conditions with entities that provide long-term services and supports.

- Existing statewide information technology or management information systems. These systems must be accessible at the state and local level.

Applicants will propose measures and evaluation strategies that will document progress toward implementing and sustaining a statewide, comprehensive access system for these programs and services. These may be performance measures related to: speed of certain processes, use of streamlined/universal assessments and applications for programs, timely enrollment in services, presence of state and local level community collaborations, presence of connections to appropriate private sector and publicly funded services.

AoA is seeking approval for data collection reporting requirements connected with its programs. Applicants will agree to collaborate with AoA in this process and, if approved, implement these additional data collection requirements, which are anticipated by the end of the second year of the award.

By the end of the cooperative agreement period, grantees must implement, and sustain the core components of streamlined access in a person-centered manner. These components must be available to at least half the population in the state by

the end of the second grant year. Applicants proposing a lesser variation than 50% of the state population or a greater time frame will have to provide extensive justification. Applicants are reminded that this will be a very competitive Program Announcement.

Objective 1, Core Component 1. Information, Referral, and Access

This function requires that the state has a highly visible and trusted place for individuals seeking objective information on the full range of services that can help them remain independent, healthy and free from abuse, neglect and exploitation in the community. Applicants are to fully describe their method(s) for achieving this and providing access to a full range of services, which may include, but are not limited to the following categories: public benefits programs; care transitions; evidence-based health programs; home and community-based services; family caregiver support programs; housing; transportation; and employment services.

Information, referral, and access involve:

- Proven outreach and marketing that serves individuals seeking assistance from public programs or access to private providers.
- A comprehensive resource database which includes information about the range of providers, programs, and services in local service areas, including those available to private payers.

Objective 1, Core Component 2. Options Counseling and Assistance

Options counseling enables individuals to understand the services available in their communities, evaluate the utility of these services, make informed decisions about the services that best meet their needs and preferences, and make the best use of their own personal and financial resources over time. Options Counseling also helps ensure that people receive services they choose, including streamlined access to services to ensure that an individual's service plan is activated. Options Counseling connects individuals to appropriate services using person-centered planning methods (see definition in Attachment G).

Options counseling involves self direction of services. Self direction enables access to services and supports that are controlled by the individual; self directed services are also a key requirement of the Older Americans Act of 1965 as Amended In 2006 (Public Law 109-365) (OAA). The OAA requires the Assistant Secretary for Aging to promote coordinated systems of care that enable individuals to receive long term services and supports (see definition in Attachment G) in home and community-based settings "in a manner responsive to the needs and preferences of older individuals and their family caregivers." Flexible spending accounts, which are integral to successful self direction, are a vehicle by which individuals directly hire their workers and directly purchase goods and services. A large, randomized-controlled trial of self direction provided evidence of the efficacy of this approach. Results included greater satisfaction with quality of services, satisfaction with

quality of life, sense of empowerment, and decreased unmet needs.[1] The grantee is to fully describe the programs and services that will offer self direction options to the individuals they serve.

By the beginning of the second year of the cooperative agreement period, State grantees that provide Options Counseling will agree to work with AoA and the National Resource Center for Participant-Directed Services to participate in core competency training (below) and agree to implement options counseling standards, which include:

- Identification of the person's strengths, values, needs, and preferences
- Service plan/action plan/next steps development
- Enrollment in self-directed programs or seamless transfer into this process
- Service initiation
- On-going assistance and follow-up
- Targeting to individuals at risk of institutionalization

Objective 1, Core Component 3. Streamlined Eligibility Determinations for Public Programs and Assistance in Applying for these Programs

Many different government programs, each with its own eligibility process, have the potential to help individuals live healthy and independent lives in the community. State grantees must make Streamlined Eligibility Determination an integral part of their state and local systems and these systems' Options Counseling functions. Agencies must implement the necessary protocols and procedures to facilitate an integrated or fully coordinated approach to performing the administrative functions necessary for public programs. These public programs may include, but are not limited to: Low Income Heating and Assistance Program (LIHEAP), Medicaid, Medicare Savings Program, Older Americans Act programs, Senior Housing programs, Supplemental Nutrition Assistance Program (SNAP), and transportation services. The required administrative functions include:

- Screening and intake of individuals for these programs
- Assessing an individual's needs for these programs
- Determining whether an individual meets or is likely to meet programmatic and financial eligibility requirements
- Assistance to the individuals who request it when they choose to apply for any of these programs
- Developing service plans for these programs as required
- Ensuring that people receive the services for which they are found to be eligible.

These processes must be both administratively efficient and seamless for individuals regardless of the program or type of service.

[1] Brown, R et al: 2005. Cash and Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or HCBS Princeton NJ: Mathematica Policy Research Inc

Objective 1, Core Component 4. Person-Centered Care Transitions across Multiple Settings

By the end of the second cooperative agreement period, grantees are to be able to offer person-centered care transition to individuals who request it. The care transitions should be evidence-based to the maximum extent possible. Applicants will establish measurable targets for achieving maximum population coverage for each year of the cooperative agreement period (e.g. 25%, 50%, 75%). Applicants are reminded that this will be a very competitive Program Announcement.

Person-centered care transitions ensure that individuals receive the information they need to make informed decisions about what services and supports work best for them and what assistance they need to facilitate delivery of these services. Person-centered care transitions involve self-direction of services For those with dementia or other conditions that result in cognitive impairment, caregivers may be involved in these decisions. Funds under this Program Announcement must provide access to dementia capable care transition services.

Randomized-controlled trials of care transitions activities (or care coordination programs with care transition elements) have shown positive results, such as significant reductions in hospital admissions and re-admissions, hospital costs, and nursing facility days. Some examples of these types of interventions include:

Care Transitions Intervention

Guided Care

Transitional Care Model

GRACE (Geriatric Resources for Assessment and Care of Elders)

BOOST (Better Outcomes for Older Adults through Safe Transitions)

The Bridge Program

Applicants are to provide the anticipated number of persons or percentage of the state's population for which a Person-Centered Care Transitions component is accessible by the end of each year of the cooperative agreement period. This component must include formal linkages between one setting of care to another and from one public program to another. These linkages include preadmission screening programs for nursing home services and hospital discharge planning programs, and discharge planning from nursing home to home. Applicants must provide information detailing the staff who will participate at these critical points to provide individuals and their families with the information they need to make informed decisions about their service and support options, and quickly arrange for the services and supports they choose.

Applicants must describe and commit to the use of electronic information systems that record information and help maintain relationships with the individual over

time and through transitions of care. Information systems should be designed to understand which populations are using the system, what services are available to them, and the services' costs, as well as to improve the quality of these services. Information systems should include linkages with other data systems, such as Medicaid information systems and electronic health records, wherever possible.

Objective 2: Ensure access to a comprehensive, sustainable set of high quality services relevant to the population residing in the state's service area.

This objective entails ensuring that individuals have access to a comprehensive, sustainable set of high quality services that are evidence-based and promote community living, health and independence for older adults, individuals with disabilities, and family caregivers. These services and supports must have a wide enough range of options to ensure maximum choice for individuals.

States develop and submit various state plans to Federal Agencies. Applicants are encouraged to use these plans to inform the ongoing operation of the comprehensive integrated system and also to assure a feedback loop in the design of the comprehensive integrated system to inform the development of future state plans. The ultimate goal is to use consumer information, perspectives, and preferences to inform the planning and development of services available in the community.

By the end of the cooperative agreement period, the State grantees' service systems must have in place the following three core components of objective 2, which include a:

1. **Comprehensive set of services**
2. **Robust quality assurance system**
3. **Sustainable service system**

Objective 2, Core Component 1. Comprehensive Set of Services.

AoA has worked with the CDC, CMS, and SAMHSA, among others, to help ensure that individuals have information about, and help in accessing a wide range of evidence-based services that promote health and independence in the community. These services must be responsive to the individual's needs and have self-direction opportunities. An example of such an opportunity is the Cash & Counseling Demonstration Program. Access to a comprehensive range of programs and services is critical to meeting Objective 2. By the end of the cooperative agreement period, State grantees must ensure that they offer to or connect individuals with the types of services listed below.

- **Dementia capable services**. A critical part of these services and supports are those proven as evidence-based to assist persons with dementia and their caregivers, such as REACH II and the New York University Caregiver Intervention.

- **Family caregiver support services**. These services must be capable of meeting a range of caregiver needs including information, access, and assistance; caregiver education, training and support groups; respite; and other supplemental services. Services and interventions are to be evidence-based or evidence-informed (see definitions in Attachment G).
- **Health promotion and disease prevention programs**. These programs are related to self management of chronic disease, exercise, falls management and prevention, medication management, mental health and substance misuse, and nutrition among others. Examples of programs include Chronic Disease Self Management Program; Matter of Balance and Tai Chi for falls management and prevention, respectively; Enhance Fitness; the Medication Management Improvement System (MMIS); and Healthy IDEAS . Please see http://www.aoa.gov/AoARoot/AoA_Programs/HPW/index.aspx for a more detailed list of the broad range of services that AoA has funded.
- **Long term services and supports**. These services include personal assistance, self and veteran-directed services, and other home and community-based services.
- **Public benefits programs**. For example, Supplemental Security Income, Medicare, Medicaid, and SNAP.
- **Care transitions services**. See previous description.
- **Related supportive services**. For example, housing, transportation, employment support, and LIHEAP.

High quality services are person-centered and, therefore must be capable of serving people with cognitive impairment, which can stem from conditions such as dementia, traumatic brain injury, intellectual and developmental disabilities, and others that affect a person's ability to manage his or her own life. Non-exclusive examples may include: seamless integration of evidence-based programs (e.g. REACH II) into the National Family Caregiver Support Program; targeted integration of Chronic Disease Self Management or Diabetes Self Management Programs with Nutrition Services Programs, especially home delivered meals. Applicants are encouraged to consider other integrative strategies.

Objective 2, Core Component 2. Robust Quality Assurance System

Grantees are to describe their implementation and use of a continuous quality assurance and improvement process that will help ensure delivery of high quality services. Quality measurement and data collection are integral parts of quality assurance. Key measures include:1) fully-functional ADRC criteria and 2) appropriate quality measures identified in other HHS initiatives such as the Partnership for Patients, Public Health Quality Initiative, Multiple Chronic Conditions Framework, etc. For more information on these initiatives see Attachment J. Descriptions of the ADRC fully-functional criteria can be found in Attachment K.

This Quality Assurance and Continuous Improvement component must also involve formal processes for getting input and feedback from individuals and their families on the integrated system's and individual agency operations and ongoing development. Applicants are to propose measurable performance goals and

indicators related to the quality assurance system's visibility, ease of access, responsiveness to individuals, efficiency and effectiveness.

Objective 2, Core Component 3: Sustainable Service System

To ensure sustainability of the comprehensive array of high quality services, including evidence-based programs, grantees must leverage existing Federal and State level initiatives. The integrated, sustainable service system is to ensure the consideration of individuals' needs while coordinating across clinical and community-based services, and leveraging opportunities for improving and streamlining services across multiple provider and community-based settings.

Grantees are to fully describe sustainable delivery systems for their comprehensive set of high quality programs by the end of the second year of the 3-year grant period, with implementation following the end of the grant period. During the project period, grantees are expected to work with Federal, State and local governments, private foundations and corporations, local and state health plans, and other public and private entities to formulate an overall strategy and detailed plan for a sustainable service system. A sustainable service system will have firm commitments for:

- State-level leadership including effective state agency partnerships with integrated state vision, documented plan and goals.
- Infrastructure and capacity to deliver programs throughout the state including effective partnerships that have effectively embedded programs within statewide health and long-term services and supports systems and organizations, and an adequate number of delivery sites and workforce to deliver the programs across the state.
- Continuation of evidence-based programs through AoA Core Programs including Titles III-B; III-C; III-D; and/or III-E.
- Centralized or coordinated outreach and marketing to promote the system to targeted groups and individuals.
- Centralized or coordinated processes for intake, referral, registration/enrollment through a SEP/NWD or similar structure.
- Quality assurance plans and ongoing data systems and procedures to provide management reports and to ensure continuous quality improvement and program fidelity throughout the state and with all partners.
- Resource development including a business plan and diversified sources of funding support.
- Collaborations with the state's community and economic development agency, department of education and department of labor to continue to develop the long-term service and supports available in communities throughout the state.

Grantees are to demonstrate that the integrated, sustainable system is connected to appropriate innovations currently undergoing development or implementation as a result of the Affordable Care Act. Applicants should note that this program announcement does not include Affordable Care Act funds. Rather, it requires grantees to ensure that any applicable Affordable Care Act initiatives in the state are integrated into the development of the statewide, comprehensive access system. For a list of these initiatives, please see Attachment J.

B. Funding Opportunity Program Structure: Part A

Successful applications will articulate the applicants' current system related to Part A of this Program Announcement's goal, objectives, and core components of these objectives.

The cooperative agreement will have two phases:

1. Planning phase that results in development of a plan acceptable to AoA related to accomplishing the goal, objectives, and core components of these objectives under this program announcement.
2. Implementation phase that carries out the state's plan for accomplishing the goal, objectives, and core components of these objectives under this program announcement.

Planning Phase:
Applicants are to propose a rapid cycle planning to implementation process. A number of these initiatives and interventions have been underway in states for 3 – 8 years. A Planning Phase of more than 6 months from the notification date of the grant award will be given exceptional scrutiny and will be open to negotiation. During this planning phase, grantees will be able to access no more than 15% of total grant funding to developing their implementation plan. During the planning phase of the grant, AoA will be actively involved. At the conclusion of the planning phase, the grantee must participate in a Planning Phase exit conference and receive the approval of AoA to progress to the Implementation Phase and access the remaining 85 percent of cooperative agreement funding.

Implementation Phase:
The grantee may not advance to the Implementation Phase without a Planning Phase Exit Conference and AoA staff's approval of their implementation plan. Upon AoA approval of the implementation plan the State grantee may begin the Implementation Phase of the grant period.

Technical Assistance:
Successful applicants are to draw on the expertise of AoA program staff and existing AoA-sponsored resources to develop, implement, and sustain their strategic plans. Please see Attachment I for a list of existing resource centers.

Once a cooperative agreement is in place, requests to modify or amend it or the work plan may be made by AoA or the awardee at any time. Modifications and/or amendments of the Cooperative Agreement or work plan shall be effective upon the mutual agreement of both parties, except where AoA is authorized under the Terms and Conditions of award, 45 CFR Part 74 or 92, or other applicable regulation or statute to make unilateral amendments.

III. ELIGIBILITY INFORMATION: PART A

1. Eligible Applicants

This is a limited competition Program Announcement. The competition is limited to State Units on Aging.

2. Cost Sharing or Matching

Under this Older Americans Act (OAA) program (i.e., Part A), AoA will fund no more than 95 % of the **project's total cost**, which means the applicant must cover at least 5% of the **project's total cost** with non-Federal resources. In other words, for every $100,000 received in Federal funding, the applicant must contribute approximately $5,263 in non-Federal resources toward the project's total cost (i.e., the amount on line 18g.). This ratio is reflected in the following formula which you can use to calculate your minimum required match:

Federal Funds Requested (i.e. amount on line 18a) times (x) Match Rate (i.e. 5%) divided by (/) Federal Match Rate (i.e. 95%) equals (=) Minimum Match Requirement

For example, if you request $2,225,000 in Federal funds, then your **minimum** match requirement is ($2,225,000 x 0.05) / (0.95), or $117,105. In this example the **project's total cost** would be $2,342,1056.

There are two types of match: 1) non-Federal cash and 2) non-Federal in-kind. In general, costs borne by the applicant and cash contributions of any and all third parties involved in the project, including sub-grantees, contractors and consultants, are considered matching funds. Volunteered time and use of facilities to hold meetings or conduct project activities may be considered in-kind (third party) donations. Examples of non-Federal cash match includes budgetary funds provided from the applicant agency's budget for costs associated with the project. Applications with a match greater than the minimum required will not receive additional consideration under the review. Match is not one of the responsiveness criteria as noted in Section III, 3 Application Screening Criteria.

If the required non-Federal share is not provided by the completion date of the funded project period, AoA will reduce the Federal dollars awarded when closing out the award to meet the match percentage, which may result in a requirement to return Federal funds.

AoA takes very seriously the current downturn in the nation's economy; therefore applicants may request a waiver of the matching requirement where severe hardship is documented by the applicant. If you feel unable to meet the minimum matching requirement, please provide a written justification, which explains why you cannot meet the match through cash or in-kind contributions. The written justification must be signed by your authorized representative and submitted with your application through http://***www.grants.gov***. AoA will review your request and

contact you should additional information or justification be necessary. Applicants are encouraged to make this hardship determination during the application phase; waiver requests made after awards have been issued will be reviewed on a case-by-case basis.

Private Pay Clients. States may propose to serve private pay clients or use client cost sharing consistent with State policy under this initiative. The discretionary funds being used for this initiative are authorized under Title IV of the Older Americans Act, and are therefore, not subject to the restrictions on serving private pay clients or on cost sharing arrangements that apply to Title III of Act.

Use of Funds. This program announcement will provide funds to develop, implement, and sustain an integrated system that offers a comprehensive set of high quality, evidence-based services that help individuals remain healthy and independent in the community. Applicants must demonstrate that the implementation of the cooperative agreement would: (a) establish new capacity or significantly enhance existing capacity; (b) does not duplicate existing work or supplant existing funding; and (c) devote all funding under the cooperative agreement to activities that implement the goals, objectives, and core components of the objectives under this program announcement.

3. Screening Criteria

Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the four screening criteria described below will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

1. Applications must be submitted electronically via http://www.grants.gov by 11:59 p.m., Eastern Time, **July 27, 2011**.

2. The Project Narrative section of the Application must be **double-spaced**, on 8 ½" x 11" plain white paper with **1" margins** on both sides, and a **font size of not less than 11**.

3. **The Project Narrative must not exceed 15 pages**. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel **are not counted** as part of the Project Narrative for purposes of the 15-page limit.

4. Applicants must be a State Unit on Aging.

IV. APPLICATION AND SUBMISSION INFORMATION: PART A

1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx.

Please note, AoA is requiring applications for all announcements to be submitted electronically through http://www.grants.gov. The Grants.gov (http://www.grants.gov) registration process can take several days. If your organization is not currently registered with http://www.grants.gov, please begin this process immediately. **For assistance with http://www.grants.gov, please contact them at** support@grants.gov **or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website (http://www.grants.gov).

Applications submitted via http://www.grants.gov:

- You may access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (HHS-2011-AoA-**AA-1113**) or CFDA number 93.048.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. AoA strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time involved to complete the registration process.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.
- Effective October 1, 2010, HHS requires all entities that plan to apply for and ultimately receive Federal grant funds from any HHS Operating/Staff Division (OPDIV/STAFFDIV) **or receive subawards directly from the recipients of those grant funds** to:
  1. Be registered in the CCR prior to submitting an application or plan;
  2. Maintain an active CCR registration with current information at all times during which it has an active award or an application or plan under consideration by an OPDIV; and
  3. Provide its DUNS umber in each application or plan it submits to the OPDIV.

  An award cannot be made until the applicant has complied with these requirements. At the time an award is ready to be made, if the intended recipient has not complied with these requirements, the OPDIV/STAFFDIV:
  - May determine that the applicant is not qualified to receive an award; and
  - May use that determination as a basis for making an award to another applicant.

Additionally, all first-tier subaward recipients must have a DUNS number at the time the subaward is made.

- Since October 1, 2003, The Office of Management and Budget has required applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.
- Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: http://www.whitehouse.gov/sites/default/files/omb/grants/duns_num_guide.pdf.
- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the http://www.grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- **Your application must comply with any page limitation requirements described in this Program Announcement.**
- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.govthat contains http://www.grants.gov tracking number. The Administration on Aging will retrieve your application form from http://www.grants.gov.
- After the Administration on Aging retrieves your application form from http://www.grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://www.grants.gov.
- Each year organizations registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (http://www.ccr.gov).

Contact person regarding this Program Announcement:

U.S. Department of Health and Human Services
Administration on Aging
Jane Tilly, DrPH
Center for Policy, Planning, and Evaluation
E-mail: jane.tilly@aoa.hhs.gov

2. Content and Form of Application Submission

a. Letter of Intent

Applicants are requested, but not required, to submit a letter of intent to apply for this funding opportunity to assist AoA in planning for the application independent review process. The purpose of the letter of intent is to allow our staff to estimate

the number of independent reviewers needed, to understand whether the applicant is applying for funding under Parts A and B of this Program Announcement, and to avoid potential conflicts of interest in the review. Note: The Assistant Secretary for Aging may give priority to those entities applying for both Parts A and B. The deadline for submission of the letter of intent is June 27, 2011. Letters of intent should be sent via email to:

Jane Tilly, DrPH
Center for Planning, Policy and Evaluation
Email: jane.tilly@aoa.hhs.gov

b. Project Narrative

The Project Narrative must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. The suggested length for the Project Narrative is ten to fifteen pages; fifteen pages is the maximum length allowed. AoA will not accept applications with a Project Narrative that exceeds 15 pages. The Project Work Plan, Letters of Commitment, and Vitae of Key Personnel are not counted as part of the Project Narrative for purposes of the 15-page limit, but all of the other sections noted below are included in the limit.

The components of the Project Narrative counted as part of the 15 page limit include:

Summary/Abstract
Systems Integration Assessment
Integration Objectives
Special Target Populations and Organizations
Outcomes
Integrated Systems Project Management
Evaluation
Dissemination
Organizational Capability Statement

Please use each of these project components as headings in your narrative.

The Project Narrative is the most important part of the application, since it will be used as the primary basis to determine whether or not your project meets the minimum requirements for grants under Title IV of the Older Americans Act. The Project Narrative should provide a clear and concise description of your project. Your project narrative must include the following components:

Summary/Abstract. This section should include a brief - no more than 265 words maximum - description of the proposed project, including: goal(s), objectives, outcomes, and products to be developed. Detailed instructions for completing the summary/abstract are included in Attachment F of this document.

System Integration Assessment. Minimum Requirements
Applicants must address **all** assessment issues in narrative format using the same headings and numerical sequence as laid out in this section**. If relevant information is provided in an appendix, you must specify the exact appendix location of that information**. This system integration assessment section should be no more than 8 double-spaced single-sided pages (documentation material to be located in indexed appendixes).

The purpose of this section is for the applicant to assess the state's readiness to implement the goals, objectives and their core components under Part A of this program announcement. Documentation must be provided to support statements made on each of the assessment issues presented below. Failure to provide documentation will result in a less than favorable score for the applicant. Examples of documentation may include legislation, regulations, memoranda of understanding/interagency agreements, letters of support from consumers, advocacy organizations and other stakeholders, state evaluation and research reports, agency progress reports, task force minutes, and data analyses.

1. Legislative and State Agency Leadership
Document the level of support for implementation of the goals, objectives and their core components under this program announcement from the various leaders in the state, and areas where consensus exists and where it is lacking among leaders. Include in this analysis the type and level of support specifically from the Governor, key legislative officials, the budget director, State Medicaid Director, and State Public Health Department Director, and other pertinent agency directors.

2. Stakeholder Support
Address the degree of interactive involvement and support of consumer/family/participant groups, local administering agencies and other pertinent entities. Areas of agreement and disagreement should be noted.

3. Progress with Meeting the Goals and Objectives of Part A of this Funding Opportunity Announcement

a. Document development of current systems integration.
b. Document the status of state or local agencies that include options counseling services, specifically noting those that have achieved fully functioning status for ADRCs (see definition in Attachment K).
c. Document the status of self directed services for all funding streams (Older Americans Act, Medicaid, state-funded programs) and the use of individual budgets.
d. Document the status of a robust quality assurance system for services.
e. Document the status of information technology that supports systems integration.
f. Document current level of state interagency and intra-agency collaboration by documenting progress and remaining challenges.
g. List all pertinent grants awarded to date with major goals achieved and not yet achieved.

h. Describe how you will overcome any current barriers to being able to hire readily state and/or contractual staff, as needed, to successfully carry out work on a system integration grant.
i. Document your state's history and ability to implement pilot projects and bring them to scale statewide.

States that have not currently achieved at least minimum integration and commitment of key stakeholders to move to a statewide integration system that meets the goals, objectives, and their core components under this program announcement will face significant challenges in securing a cooperative agreement under this Program Announcement.

The grant awards will be based upon review of the individual proposals and the accompanying budget documentation.

Integration Objectives.
Applicants' proposals must address in detail all the goals, objectives, and their core components under Part A of this Program Announcement. This integration objectives section should be no more than 8 double-spaced single-sided pages (documentation material to be located in indexed appendixes).

The application must, for each of the two objectives and their core components (objectives 1 and 2 must have separate sections):

- Provide the underlying conceptual framework and methods that will be used to meet the objective.
- Discuss the strategies the applicant will use to achieve each of the objectives and its core components.
- Provide a summary of what the applicant will have accomplished at the end of the 12, 24 and 36 month cooperative agreement periods in achieving the two objectives and their core components. This summary must: identify which metrics the applicant would use to measure progress toward attaining these objectives. Applicants must use quantitative metrics to the extent possible.
- Describe the performance measures, indicators and data elements the applicant would voluntarily report to measure progress toward implementation of the two objectives and their core components.
- Describe the capacity and qualifications of key State and local staff to participate in the development, implementation and measurement of progress toward attainment of the goals, objectives and core components of the objectives. Organizational charts and vitas will not count towards the narrative page limit.

Special Target Populations and Organizations. This section should describe how the applicant plans to involve community-based organizations in a meaningful way in the planning and implementation of the integrated systems project. This section should also describe how the proposed intervention will target underserved populations, including limited-English speaking populations.

Outcomes. This section of the project narrative must clearly identify the measurable outcome(s) that will result from the integrated systems project.

(NOTE: AoA will not fund any project that does not include measurable outcomes). This section should also describe how the project's findings might benefit the field at large, (e.g., how the findings could help other organizations throughout the nation to address the same or similar problems.) List measurable outcomes in the attached work plan grid (Attachment E) under "Measurable Outcomes" in addition to any discussion included in the narrative along with a description of how the project might benefit the field at large.

A "measurable outcome" is an observable end-result that describes how a particular intervention benefits consumers. It demonstrates the functional status, mental well-being, knowledge, skill, attitude, awareness or behavior. It can also describe a change in the degree to which consumers exercise choice over the types of services they receive, or whether they are satisfied with the way a service is delivered. Additional examples include: a change in the responsiveness or cost-effectiveness of a service delivery system; a new model of support or care that can be replicated in the aging network; new knowledge that can contribute to the field of aging; a measurable increase in community awareness; or a measurable increase in persons receiving services. A measurable outcome is not a measurable "output", such as: the number of clients served; the number of training sessions held; or the number of service units provided.

The applicant should keep the focus of this section on describing what outcome(s) will be produced by the integrated systems project. Applicants should use the Evaluation section noted below to describe how the outcome(s) will be measured and reported.

The application will be scored on the clarity and nature of the proposed outcomes, not on the number of outcomes cited.

Integrated Systems Project Management. This section should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. It should specify who would have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports; and communications with other partners and AoA. It should also describe the approach that will be used to monitor and track progress on the project's tasks and objectives.

Evaluation. This section should describe the method(s), techniques and tools that will be used to: 1) determine whether or not the proposed integrated systems project achieved its anticipated outcome(s), and 2) document the "lessons learned" – both positive and negative – from the project that will be useful to people interested in replicating it, if it proves successful.

Dissemination. This section should describe the method that will be used to disseminate the integrated system project's results and findings in a timely manner and in easily understandable formats, to parties who might be interested in using the results of the project to inform practice, service delivery, program development,

and/or policy-making, including and especially those parties who would be interested in replicating the project.

Organizational Capability Statement. Each application should include an organizational capability statement and vitae for key project personnel. The organizational capability statement should describe how the applicant agency (or the particular division of a larger agency which will have responsibility for this project) is organized, the nature and scope of its work and/or the capabilities it possesses. It should also include the organization's capability to sustain some or all project activities after Federal financial assistance has ended. This description should cover capabilities of the applicant agency not included in the program narrative, such as any current or previous relevant experience and/or the record of the project team in preparing cogent and useful reports, publications, and other products. If appropriate, include an organization chart showing the relationship of the project to the current organization. Please attach short vitae for key project staff only. Neither vitas nor an organizational chart will count towards the narrative page limit. Also include information about any contractual organization(s) that will have a significant role(s) in implementing project and achieving project goals.

c. Work Plan

The Integrated Systems Project Work Plan should reflect and be consistent with the Project Narrative and Budget and should cover all three (3) years of the project period. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks / action steps that will be pursued to achieve the goal and outcome(s). For each major task / action step, the work plan should identify timeframes involved (including start-and end-dates), and the lead person responsible for completing the task. Please use the Sample Work Plan format included in Attachment E. AoA projects at least 3 national meetings with grantees during the grant period. Applicants should plan and budget to send 3 representatives to each of these 3 national meetings.

d. Letters of Commitment from Key Participating Organizations and Agencies

Include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations and agencies in this part of the application. Any organization that is specifically named to have a significant role in carrying out the project should be considered an essential collaborator. For applications submitted electronically via http://*www.grants.gov*, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the AoA Office of Grants Management at 202-357-3467 by the application submission deadline. In your fax, be sure to include the funding opportunity number and your agency name.

e. Budget Narrative/Justification

The Budget Narrative/Justification should be provided using the format included as Attachment C of this Program Announcement. Applicants are encouraged to pay particular attention to Attachment C, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required

3. Submission Dates and Times

The deadline for the submission of applications under this Program Announcement is July 27, 2011. Applications must be submitted electronically by 11:59 p.m. Eastern Time, July 27, 2011.

Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties, either on your end or, with *http://www.grants.gov*. Grants.gov can take up to 48 hours to notify you of a successful submission.

Unsuccessful submissions will require authenticated verification from *http://www.grants.gov* indicating system problems existed at the time of your submission. For example, you will be required to provide an *http://www.grants.gov* submission error notification and/or tracking number in order to substantiate missing the cut off date.

Grants.gov (http://*www.grants.gov*) will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in http://*www.grants.gov*. After AoA retrieves your application form from http://*www.grants.gov*, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://*www.grants.gov*.

4. Intergovernmental Review

This program announcement is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

5. Funding Restrictions

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings
- Basic research (e.g. scientific or medical experiments)
- Continuation of existing projects without expansion or new and innovative approaches.
- Pre-award costs

6. Other Submissions Requirements

Letters of intent should be emailed to:

Jane Tilly, DrPH
Email: jane.tilly@aoa.hhs.gov

V. APPLICATION REVIEW INFORMATION: PART A

1. Criteria

Applications are scored by assigning a maximum of 100 points across five criteria:

a. Project Relevance and Current Need (Systems Integration Assessment) - (15 points);

b. Approach (Integration Objectives) - (20 points);

c. Budget – (10 points);

d. Project Impact - (35 points); and

e. Organizational Capacity - (20 points).

a. Project Relevance and Current Need (Systems Integration Assessment) Weight: 15 points

i. Does the proposed project clearly and adequately identify the relevance of the goals, objectives, and core components, as described in Part A of this Program Announcement, in relation to current state/community needs? (10 points).

ii. Does the application adequately and appropriately describe and document the key problem(s)/condition(s) and strengths of the current health, long-term services and supports, and related services systems relevant to the goals, objectives, and their core components, as described in Part A of this Program Announcement? Is the proposed project justified in terms of the most recent, relevant, and available information and knowledge? (5 points)

b. Approach (Integration Objectives) Weight: 20 points

i. Is the integrated systems project clearly defined? Does it reflect a coherent and feasible approach for successfully achieving Part A of this Program Announcement's identified goals, objectives, and core components of the objectives? Does the project take into account barriers and opportunities that exist in the larger environment that may have an impact on the project's success? Does the proposal optimize the use of potential partnerships with other organizations

and/or consumer groups, as required in Part A of this Program Announcement? (5 points)

ii. Is the project work plan clear and comprehensive? Does it include sensible and feasible timeframes for the accomplishment of Part A of this Program Announcement's goals, objectives, and core components of the objectives? Does the work plan include specific objectives and tasks that are linked to measurable outcomes? Does the proposal include a clear and coherent management plan? Are the roles and responsibilities of project staff, consultants and partners clearly defined and linked to Part A of this Program Announcement's identified goals, objectives, and core components of the objectives? (10 points)

iii. Does the application describe how local community-based organizations, including but not limited to AAAs, CILS, ADRCs will be involved in a meaningful way in the planning and implementation of the proposed project? Does the application address the special needs of persons with cognitive impairment, persons with disabilities (including persons with physical, intellectual and developmental disabilities), their family caregivers, and underserved populations, such as limited-English speaking populations, in its target population? (5 points)

c. Budget **Weight: 10 points**

i. Is the budget justified with respect to the adequacy and reasonableness of resources requested? Is the time commitment of the proposed director and other key project personnel sufficient to assure proper direction, management and timely completion of the project? (5 points)

ii. Are budget line items clearly delineated and consistent with work plan objectives? For example, has a multiyear budget covering the entire proposed project period been included as well as a budget covering each individual year? (5 points)

d. Project Impact **Weight: 35 points**

i. Are the expected project benefits/results clear, realistic, and consistent with Part A of this Program Announcement's goals, objectives and core components of the objectives, including the numbers/percentages of the population to be served? Are the anticipated outcomes of the proposed project likely to be achieved and will they significantly benefit the populations affected by the intervention, and the field of aging as a whole? Are the proposed outcomes quantifiable and measurable, consistent with the definition of a project outcome contained in Part A of this Program Announcement?
(10 points)

ii. Does the project reflect a thoughtful and well-designed evaluation that will be able to successfully measure whether or not the project has achieved Part A of this Program Announcement's goals, objectives, and core components of objectives? Does the plan include the qualitative and/or quantitative methods necessary to reliably measure outcomes? Is the evaluation designed to capture "lessons learned" from the overall effort that might be of use to others in the fields of aging and disability, especially those who might be interested in replicating the project? Has

the applicant agreed to work with AoA and comply with any OMB approved reporting requirements? (10 points)

iii. Is there a realistic plan to ensure that resources are available to continue all project activities after Federal financial assistance has ended? (10 points)

iv. Will the dissemination plan get relevant and easy to use information in a timely manner to parties that might be interested in making use of its findings, particularly to those who might want to replicate the integrated systems project? (5 points)

e. Organizational Capacity **Weight: 20 points**

i. Does the applicant organization clearly identify its capacity for carrying out the proposed project and evaluation? Do key staff have time commitments allocated that are sufficient to carry out a project of this scope? (10 points)

ii. Do the proposed project director(s), key staff and consultants have the background, experience, and other qualifications required to carry out their designated roles? Are letters from participating organizations included, as appropriate, and do they express the clear commitment and areas of responsibility of those organizations, consistent with the work plan description of their intended roles and contributions? (10 points)

2. Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria if applicable. These reviewers are experts in their field, and are drawn from academic institutions, non-profit organizations, state and local government, and Federal government agencies. Based on the Application Review Criteria as outlined under section V.1, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Applicants have the option of omitting from the application copies (not the original) of specific salary rates or amounts for individuals specified in the application budget. Please do not include Social Security Numbers in your submission.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results; the likelihood that the proposed project will result in the benefits expected and **whether the applicant has applied for Parts A and B of this Program Announcement**.

3. Anticipated Announcement Award Date

Applicants can expect to learn about the disposition of their applications, whether successful or unsuccessful no later than September 30, 2011.

VI. AWARD ADMINISTRATION INFORMATION: PART A

1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration on Aging authorizing official, Officer of Grants Management, and the AoA Office of Budget and Finance. Unsuccessful applicants are generally notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail. Unless indicated otherwise in this announcement, unsuccessful applications will not be retained by the agency and destroyed.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement located at *http://www.hhs.gov/grantsnet/adminis/gpd/index.htm*.

3. Reporting

Effective March 1, 2011, AoA requires the submission of the SF-425 (Federal Financial Report). The AoA program progress report is due semi-annually from the start date of the award. Final performance and SF-425 reports are due 90 days after the end of the project period.

Grantees are required to complete the federal cash transactions portion of the SF-425 within the Payment Managements System as identified in their award documents for the calendar quarters ending 3/31, 6/30, 9/30, and 12/31 through the life of their award. In addition, the fully completed SF-425 will be required as denoted in the Notice of Award terms and conditions.

4. FFATA and FSRS Reporting

The Federal Financial Accountability and Transparency Act (FFATA) requires data entry at the FFATA Subaward Reporting System (http://www.FSRS.gov) for all sub-awards and sub-contracts issued for $25,000 or more as well as addressing executive compensation for both grantee and sub-award organizations.

For further guidance please see the following link:
http://www.aoa.gov/aoaroot/grants/ARRA_Terms/docs/Requirements_for_FFATA.pdf

VII. AGENCY CONTACTS: PART A

Project Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Jane Tilly
E-mail: jane.tilly@aoa.hhs.gov

Grants Management Specialist:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Rebecca Mann
e-mail: Rebecca.mann@aoa.hhs.gov

VIII. OTHER INFORMATION: PART A

1. Application Elements

a. SF 424 – Application for Federal Assistance (See Attachment A for Instructions).

b. SF 424A – Budget Information. (See Attachment A for Instructions; See Attachment B for an example of a completed SF 424A).

c. Separate Budget Narrative/Justification (See Attachment C for a Budget Narrative/Justification Sample Format with Examples and Attachment D for a Sample Template).
NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a Narrative/Justification for each year of potential grant funding, as well as a combined multi-year detailed Budget Narrative/Justification.

d. SF 424B – Assurances. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

e. Lobbying Certification

f. Proof of non-profit status, if applicable

g. Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

h. Project Narrative with Work Plan (See Attachment E, for Sample Work Plan Format).

i. Organizational Capability Statement and Vitae for Key Project Personnel.

j. Letters of Commitment from Key Partners, if applicable.

2. The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The project description and Budget Narrative/Justification is approved under OMB control number 0985-0018 which expires on 8/31/13. Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

PART B: Creating Dementia Capable, Sustainable Service Systems For Persons With Dementia And Their Family Caregivers

I. FUNDING OPPORTUNITY DESCRIPTION: PART B

Statutory Authority

The statutory authority for grant awards for the Alzheimer's Disease Supportive Services Program (ADSSP) is contained in Sec. 398 of the Public Health Service Act (P.L. 78-410; 42 U.S.C. 280c-3), available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=browse_usc&docid=Cite:+42USC280c-3
It was amended by the Home Health Care and Alzheimer's Disease Amendments of 1990 (PL 101-557) and by the Health Professions Education Partnerships Act of 1998 (PL 105-392).

II. AWARD INFORMATION: PART B

The Administration on Aging (AoA) will award approximately $2.6 million in competitive cooperative agreements to State Units on Aging through this initial Funding Opportunity Announcement entitled: ***Creating Dementia Capable, Sustainable Service Systems for Persons with Dementia and their Family Caregivers***. This new funding opportunity will award cooperative agreements to 4 to 7 successful applicants that agree to implement and sustain a dementia capable service system as described in this Program Announcement. The funding period is 3 years, with an anticipated start date of September 30, 2011. Cooperative agreement amounts are expected to range from $370,000 to $1,000,000 for each 3 year grant. Awards will be fully funded for the 3 year grant period.

A. Funding Opportunity Goal and Objectives: Part B

The overall purpose of this program announcement is to ensure that persons with dementia and their family caregivers have clear and ready access to a sustainable, integrated system that offers a comprehensive set of high quality, evidence-based or evidence-informed services that can help them remain independent and healthy in the community. Creating this system involves building upon and integrating existing programs:1) between states and communities, and 2) across health and human service systems. The resulting systems must meet this Program Announcement's two objectives and their core components.

Applicants are encouraged to apply for Part A and Part B of this Funding Opportunity Announcement. Part A is entitled, ***Accelerating Integrated, Evidence-based, and Sustainable Service Systems for Older Adults, Individuals with Disabilities and Family Caregivers and found under*** **HHS-2011-AoA-AA-1113**

Objective 1: Coordinate the integration of a statewide set of programs that includes a Single Entry Point/No Wrong Door (SEP/NWD) access for individuals

A statewide system is one in which persons with dementia and their family caregivers anywhere in the state have streamlined access to the full array of public and private sector programs and services that promote community living, health and independence. The core components of objective 1 include:

1. **Information, Referral and Access**
2. **Options Counseling and Assistance**
3. **Streamlined Eligibility Determinations for Public Programs and Assistance in Applying for these Programs**
4. **Person-Centered Care Transitions across Multiple Settings**

These core components are to be integrated through community-wide systems of information, counseling and access, offering a single point of entry for services or a "no wrong door" approach to accessing services. Access to services is to be seamless, regardless of the programs the persons with dementia or their caregivers use.

In developing and implementing the statewide access system, grantees must build on:

- Existing access points, such as Area Agencies on Aging (AAAs); Aging and Disability Resource Centers (ADRCs); Benefits Enrollment Centers (BECs), Centers for Independent Living (CILs), and State Heath Insurance Assistance Programs (SHIPs).

- Disability and Dementia capable services/systems. Comprehensive single points of entry, No Wrong Door or other comparable approaches must provide or seamlessly connect with entities that provide long-term services and supports.

- Existing statewide information technology or management information systems. These systems must be accessible at the state and local level.

Applicants will propose measures and evaluation strategies that will document progress toward implementing and sustaining a statewide, comprehensive access system for these programs and services. These may be performance measures related to: speed of certain processes, use of streamlined/universal assessments and applications for programs, timely enrollment in services, presence of state and local level community collaborations, presence of connections to appropriate private sector and publicly funded services.

By the end of the cooperative agreement period, grantees must implement, and sustain the core components of streamlined access in a person-centered and "dementia capable" manner. These components must be available to at least half the population in the state by the end of the second grant year. Applicants

proposing a lesser variation than 50% of the state population or a greater time frame will have to provide extensive justification.

Objective 1, Core Component 1. Information, Referral, and Access

This function requires that the state has a highly visible and trusted place for persons with dementia and their family caregivers to seek objective information on the full range of services that can help them remain independent, healthy and free from abuse, neglect and exploitation in the community. Applicants are to fully describe their method(s) for achieving this and providing access to a full range of services, which may include, but are not limited to the following categories: public benefits programs; care transitions; evidence-based health programs; home and community-based services; family caregiver support programs; housing; transportation; and employment services.

Information, referral, and access involve:

- Proven outreach and marketing that serves persons with dementia and their family caregivers seeking assistance from public programs or access to private providers.
- A comprehensive resource database which includes information about the range of dementia capable providers, programs, and services in local service areas, including those available to private payers.

Objective 1, Core Component 2. Options Counseling and Assistance

Options counseling enables persons with dementia and their family caregivers to understand the services available in their communities, evaluate the utility of these services, make informed decisions about the services that best meet their needs and preferences, and make the best use of their own personal and financial resources over time. Options Counseling also helps ensure that people receive services they choose, including streamlined access to services to ensure that an individual's service plan is activated. Options Counseling connects persons with dementia and their family caregivers to appropriate services using person-centered and dementia capable planning methods (see definitions in Attachment G).

Options counseling involves self direction of services. Self direction enables access to services and supports that are controlled by the person or the person's family caregiver, if appropriate. Self directed services are also a key requirement of the Older Americans Act of 1965 as Amended In 2006 (Public Law 109-365) (OAA). The OAA requires the Assistant Secretary for Aging to promote coordinated systems of care that enable persons to receive long term services and supports (see definition in Attachment G) in home and community-based settings "in a manner responsive to the needs and preferences of older individuals and their family caregivers." Flexible spending accounts, which are integral to successful self direction, are a vehicle by which persons with dementia or the person's family caregiver, if appropriate, directly hire their workers and directly purchase goods and services. A large, randomized-controlled trial of self direction provided evidence of the efficacy of this approach. Results included greater satisfaction with

quality of services, satisfaction with quality of life, sense of empowerment, and decreased unmet needs.[2] The grantee is to fully describe the programs and services that will offer self direction options to persons with dementia and their family caregivers.

By the end of the second year of the cooperative agreement period, State grantees that provide Options Counseling will agree to work with AoA and the National Resource Center for Participant-Directed Services to participate in core competency training (below) and agree to implement options counseling standards which include:

- Identification of the person's strengths, values, needs, and preferences
- Service plan/action plan/next steps development
- Enrollment in self-directed programs or seamless transfer into this process
- Service initiation
- On-going assistance and follow-up

Objective 1, Core Component 3. Streamlined Eligibility Determinations for Public Programs and Assistance in Applying for these Programs

Many different government programs, each with its own eligibility process, have the potential to help persons with dementia and their family caregivers to live healthy and independent lives in the community. State grantees must make Streamlined Eligibility Determination an integral part of their state and local systems and these systems' Options Counseling functions. Agencies must implement the necessary protocols and procedures to facilitate an integrated or fully coordinated approach to performing the administrative functions necessary for public programs. These public programs may include, but are not limited to: Low Income Heating and Assistance Program (LIHEAP), Medicaid, Medicare Savings Program, Older Americans Act programs, Senior Housing programs, Supplemental Nutrition Assistance Program (SNAP), and transportation services. The required administrative functions include:

- Screening and intake of persons with dementia and their family caregivers for these programs
- Assessing a person's needs for these programs
- Determining whether a person meets or is likely to meet programmatic and financial eligibility requirements
- Assistance to persons who request it when they choose to apply for any of these programs
- Developing service plans for these programs as required
- Ensuring that persons receive the services for which they are found to be eligible.

[2] Brown, R et al: 2005. Cash and Counseling: Improving the Lives of Medicaid Beneficiaries Who Need Personal Care or HCBS Princeton NJ: Mathematica Policy Research Inc

These processes must be both administratively efficient and seamless for persons with dementia and their family caregivers regardless of the program or type of service.

Objective 1, Core Component 4. Person-Centered and Dementia Capable Care Transitions across Multiple Settings

By the end of the second cooperative agreement period, grantees are to be able to offer person-centered care transitions to persons with dementia and their family caregivers. The care transitions should be evidence-based to the maximum extent possible. Applicants will establish measurable targets for achieving maximum population coverage for each year of the cooperative agreement period (e.g. 25%, 50%, 75%). Applicants are reminded that this will be a very competitive Program Announcement.

Person-centered care transitions ensure that persons with dementia and their family caregivers receive the information they need to make informed decisions about what services and supports work best for them and what assistance they need to facilitate delivery of these services. Person-centered care transitions involve self-direction of services for those with dementia and their caregivers. Funds under this Program Announcement must provide access to dementia capable care transition services.

Randomized-controlled trials of care transitions activities (or care coordination programs with care transition elements) have shown positive results, such as significant reductions in hospital admissions and re-admissions, hospital costs, and nursing facility days. Some examples of these types of interventions include:

Care Transitions Intervention

Guided Care

Transitional Care Model

GRACE (Geriatric Resources for Assessment and Care of Elders)

BOOST (Better Outcomes for Older Adults through Safe Transitions)

The Bridge Program

Applicants are to provide the anticipated number of persons or percentage of the state's population with dementia for which a Person-Centered Care Transitions component is accessible by the end of each year of the cooperative agreement period. This component must include formal linkages between one setting of care to another and from one public program to another. These linkages include preadmission screening programs for nursing home services and hospital discharge planning programs, and discharge planning from nursing home to home. Applicants must provide information detailing the staff who will participate at these critical points to provide persons with dementia and their family caregivers with the

information they need to make informed decisions about their service and support options, and quickly arrange for the services and supports they choose.

Applicants must describe and commit to the use of electronic information systems that record information and help maintain relationships with the individual over time and through transitions of care. Information systems should be designed to understand which populations are using the system, what services are available to them, and the services' costs, as well as to improve the quality of these services. Information systems should include linkages with other data systems, such as Medicaid information systems and electronic health records, wherever possible.

Applicants will be required to collect OMB approved data (OMB approval # 0985-0022) for **Alzheimer's Disease Supportive Services Program** services (see http://www.adrc-tae.org/tiki-download_file.php?fileId=29772 to view the data spreadsheet). In addition, AoA is seeking approval for other data collection reporting requirements. Applicants will agree to collaborate with AoA in this process and, if approved, implement these additional data collection requirements, which are anticipated by the end of the second year of the award.

Objective 2: Ensure access to a comprehensive, sustainable set of high quality services relevant to the population residing in the state's service area.

This objective entails ensuring that persons with dementia and their caregivers have access to a comprehensive, sustainable set of high quality services that are: 1) evidence-based or evidence-informed, 2) dementia capable, and 3) promote community living, health and independence. These services and supports must have a wide enough range of options to ensure maximum choice for persons with dementia and their family caregivers.

States develop and submit various state plans to Federal Agencies. Applicants are encouraged to use these plans to inform the ongoing operation of the comprehensive integrated system and also to assure a feedback loop in the design of the comprehensive integrated system to inform the development of future state plans. The ultimate goal is to use consumer information, perspectives, and preferences to inform the planning and development of services available in the community.

By the end of the cooperative agreement period, the State grantees' service systems must have in place the following three core components of objective 2, which include a:

1. **Comprehensive set of services**
2. **Robust quality assurance system**
3. **Sustainable service system**

Objective 2, Core Component 1. Comprehensive Set of Services.

AoA has worked with the CDC, CMS, and SAMHSA, among others, to help ensure

that persons with dementia and their family caregivers have information about, and help in accessing a wide range of evidence-based services that promote health and independence in the community. These services must be responsive to the individual's needs and have self-direction opportunities. An example of such an opportunity is Cash & Counseling. Access to a comprehensive range of programs and services is critical to meeting Objective 2. By the end of the cooperative agreement period, State grantees must ensure that they offer to or connect persons with dementia and their family caregivers with the types of services listed below.

- **Dementia capable services**. A critical part of these services and supports are those proven as evidence-based to assist persons with dementia and their caregivers, such as REACH II and the New York University Caregiver Intervention.
- **Family caregiver support services**. These services must be capable of meeting a range of caregiver needs including information, access, and assistance; caregiver education, training and support groups; respite; and other supplemental services. Services and interventions are to be evidence-based or evidence-informed (see definitions in Attachment G).
- **Health promotion and disease prevention programs**. These programs are related to self management of chronic disease, exercise, falls management and prevention, medication management, mental health and substance misuse, and nutrition among others. Examples of programs include Chronic Disease Self Management Program; Matter of Balance and Tai Chi for falls management and prevention, respectively; Enhance Fitness; the Medication Management Improvement System (MMIS); and Healthy IDEAS . Please see http://www.aoa.gov/AoARoot/AoA_Programs/HPW/index.aspx for a more detailed list of the broad range of services that AoA has funded.
- **Long term services and supports**. These services include personal assistance, self and veteran-directed services, and other home and community-based services.
- **Public benefits programs**. For example, Supplemental Security Income, Medicare, Medicaid, and SNAP.
- **Care transitions services**. See previous description.
- **Related supportive services**. For example, housing, transportation, employment support, and LIHEAP.

High quality services are person-centered and, therefore must be dementia-capable; that is, tailored to the unique needs of persons with dementia stemming from conditions such as Alzheimer's disease and related disorders, and their caregivers. For example:

- Information and assistance should identify those with dementia.
- Options counseling staff should understand how best to communicate with persons with dementia and their family caregivers.
- The services to which persons with dementia are referred should meet their unique needs. For example, persons with dementias, such as Alzheimer's disease, must have access to "dementia capable" providers who deliver services that are tailored to their needs. Effective interventions begin at the

earliest stages of the disease, although most community-based programs are focused on the middle stages when families are already in crisis.

- Self directed services should: ensure that persons with dementia are supported in their decision-making about services and involve family caregivers when necessary.

Grantees must use Alzheimer's Disease Supportive Services Program (ADSSP) funds provided under the Public Health Services Act to ensure that services are dementia capable. **See Attachment H for a description of the special requirements that all grantees must meet when using ADSSP funds. Grantees must ensure that <u>all</u> dementia capable services and supports that persons receive are evidence-based or evidence-informed (definitions provided in Attachment G).**

Objective 2, Core Component 2. Robust Quality Assurance System

Grantees are to describe their implementation and use of a continuous quality assurance and improvement process that will help ensure delivery of high quality, dementia capable services. Quality measurement and data collection are integral parts of quality assurance. Key measures include: 1) fully-functional ADRC criteria and 2) appropriate quality measures identified in other HHS initiatives such as the Partnership for Patients, Public Health Quality Initiative, Multiple Chronic Conditions Framework, etc. For more information on these initiatives see Attachment J. Descriptions of the ADRC fully-functional criteria can be found in Attachment K.

This Quality Assurance and Continuous Improvement component must also involve formal processes for getting input and feedback from individuals and their families on the integrated system's and individual agency operations and ongoing development. Applicants are to propose measurable performance goals and indicators related to the quality assurance system's visibility, ease of access, responsiveness to persons with dementia and their family caregivers, efficiency and effectiveness.

Objective 2, Core Component 3: Sustainable Service System

To ensure sustainability of the comprehensive array of high quality services, including evidence-based and evidence-informed programs, grantees must leverage existing Federal and State level initiatives. The integrated, sustainable service system is to ensure the consideration of persons' needs while coordinating across clinical and community-based services, and leveraging opportunities for improving and streamlining services across multiple provider and community-based settings.

Grantees are to fully describe sustainable delivery systems for their dementia capable programs by the end of the second year of the 3-year grant period, with implementation following the end of the grant period. During the project period, grantees are expected to work with Federal, State and local governments, private foundations and corporations, local and state health plans, and other public and

private entities to formulate an overall strategy and detailed plan for a sustainable service system. A sustainable service system will have firm commitments for:

- State-level leadership including effective state agency partnerships with integrated state vision, documented plan and goals.
- Infrastructure and capacity to deliver programs throughout the state including effective partnerships that have effectively embedded programs within statewide health and long-term services and supports systems and organizations, and an adequate number of delivery sites and workforce to deliver the programs across the state.
- Continuation of evidence-based or evidence-informed programs through AoA Core Programs including Titles III-B; III-C; III-D; and/or III-E.
- Centralized or coordinated outreach and marketing to promote the system to targeted groups and persons with dementia and their family caregivers.
- Centralized or coordinated processes for intake, referral, registration/enrollment through a SEP/NWD or similar structure.
- Quality assurance plans and ongoing data systems and procedures to provide management reports and to ensure continuous quality improvement and program fidelity throughout the state and with all partners.
- Resource development including a business plan and diversified sources of funding support. Resource development including a business plan and diversified sources of funding support.
- Collaborations with the state's community and economic development agency, department of education and department of labor to continue to develop the long-term service and supports available in communities throughout the state.

Grantees are to demonstrate that the integrated, sustainable system is connected to appropriate innovations currently undergoing development or implementation as a result of the Affordable Care Act. Applicants should note that this program announcement does not include Affordable Care Act funds. Rather, it requires grantees to ensure that any applicable Affordable Care Act initiatives in the state are integrated into the development of the statewide, comprehensive access system. For a list of these initiatives, please see Attachment J.

B. Funding Opportunity Program Structure: Part B

Successful applications will articulate the applicants' current system related to Part B of this Program Announcement's goal, objectives, and core components of these objectives.

The cooperative agreement will have two phases:

1. Planning phase that results in development of a plan acceptable to AoA related to accomplishing the goal, objectives, and core components of these objectives under this program announcement.
2. Implementation phase that carries out the state's plan for accomplishing the goal, objectives, and core components of these objectives under this program announcement.

Planning Phase:

Applicants are to propose a rapid cycle planning to implementation process. A number of these initiatives and interventions have been underway in states for 3 – 8 years. A Planning Phase of more than 6 months from the notification date of the grant award will be given exceptional scrutiny and will be open to negotiation. During this planning phase, grantees will be able to access no more than 15% of total grant funding to developing their implementation plan. During the planning phase of the grant, AoA will be actively involved. At the conclusion of the planning phase, the grantee must participate in a Planning Phase exit conference and receive the approval of AoA to progress to the Implementation Phase and access the remaining 85 percent of cooperative agreement funding.

Implementation Phase:
The grantee may not advance to the Implementation Phase without a Planning Phase Exit Conference and AoA staff's approval of their implementation plan. Upon AoA approval of the implementation plan the State grantee may begin the Implementation Phase of the grant period.

SPECIAL REQUIREMENTS FOR USE OF FUNDS UNDER PART B
States must use these Alzheimer's Disease Supportive Services Program (ADSSP) funds, which are provided under the Public Health Services Act, to implement dementia capable systems under this program announcement. The ADSSP has specific requirements that shape the use of funds:

- The statute governing the ADSSP program requires that grantees provide a 25% match (cash and/or in-kind) during the first year, 35% during the second year, and 45% during the third and subsequent years of the grant period. Waivers to these match requirements are not permitted under the Public Health Services Act.
- The statute governing the ADSSP program states, "the State agrees to expend not less than 50 percent of the federal grant funds for the provision of [direct] services" to persons with Alzheimer's disease or related dementias and their families.
- Those services which are listed as "direct services" in the program's statute are: "…home health care, personal care, [adult] day care, companion services, short-term care in health facilities, and other respite care to individuals with Alzheimer's disease or related disorders that are living in single family homes or congregate settings." For this program announcement, respite is defined as an interval of rest or relief **OR** the result of a direct service intervention that generates rest or relief for the person with dementia and/or their family caregiver. For example, if people with dementia and/or their family caregivers receive counseling or training through an intervention, the intervention will be considered to have generated respite for the participants. This may be considered part of the direct service requirement.
- States are not allowed to make payments with grant funds under this Announcement for any items or services to the extent that payment has been made, or can reasonably be expect to be made, with respect to such item or service under any State compensation program, under an insurance policy,

or under any State or Federal health benefits program, such as Medicare and Medicaid, or an entity that provides health services on a prepaid basis.

- The statute governing the ADSSP program also states, "… the State agrees that not more than 10 percent of the grant will be expended for administrative expenses with respect to the grant."
- There are no age restrictions on who may be served through the ADSSP Program. Any person with Alzheimer's disease or a related dementia or their caregiver, regardless of age, is eligible for ADSSP services.
- In the ADSSP statute, there is a particular focus on providing access to services to individuals, "who are members of racial or ethnic minority groups, who have limited proficiency in speaking the English language, or who live in rural areas." Applicants that propose robust efforts to service this population will receive highly favorable consideration under this Program Announcement.

Technical Assistance:
Successful applicants are to draw on the expertise of AoA program staff and existing AoA-sponsored resources to develop, implement, and sustain their strategic plans. Please see Attachment I for a list of existing resource centers.

Once a cooperative agreement is in place, requests to modify or amend it or the work plan may be made by AoA or the awardee at any time. Modifications and/or amendments of the Cooperative Agreement or work plan shall be effective upon the mutual agreement of both parties, except where AoA is authorized under the Terms and Conditions of award, 45 CFR Part 74 or 92, or other applicable regulation or statute to make unilateral amendments.

III. ELIGIBILITY INFORMATION: PART B

1. Eligible Applicants

This is a limited competition Program Announcement. The competition is limited to State Units on Aging.

2. Cost Sharing or Matching

Section 398 of the Public Health Service Act (42 U.S.C. 398 et seq.), as amended, requires that grantees provide a 25% match of total costs during the first year of an ADSSP project, 35% during the second year, and 45% during the third and subsequent years of the cooperative agreement period. **Match can be made cash or in-kind**. Match does not need to come from the state grantee; it can be contributed by any non-federal sources and it can come from multiple partners. Waivers to these match requirements are not allowed.

The formula for calculating the required match is:

Federal Funds requested (i.e. $300,000) times (x) Match Rate (i.e. 25%, 35%, 45%) divided by (/)
Federal Match Rate (i.e.75%, 65%, 55%) equals (=) Project Match

For this cooperative agreement opportunity, three (3) individual annual (12 month) budgets must be submitted to AoA for each project: 1) Year One 12-month budget with 25% match, 2) Year Two 12-month budget with 35% match, and 3) Year Three 12-month budget with 45% match. Each budget must have a corresponding budget justification. Attachment B contains a template Budget Justification. Please note that there are headers on the budget justification template where you should note the budget interval and match requirement for that interval on each page.

There are two types of match: 1) non-Federal cash and 2) non-Federal in-kind. In general, costs borne by the applicant and cash contributions of any and all third parties involved in the project, including sub-grantees, contractors and consultants, are considered matching funds. Volunteered time and use of facilities to hold meetings or conduct project activities may be considered in-kind (third party) donations. Examples of non-Federal cash match includes budgetary funds provided from the applicant agency's budget for costs associated with the project. Applications with a match greater than the minimum required will not receive additional consideration under the review. Match is not one of the responsiveness criteria as noted in Section III, 3 Application Screening Criteria.

Waivers of the ADSSP match requirements are not permitted under the Public Health Services Act. AoA will fund no more than 75% of the project's total cost in Year 1, 65% of the project's total cost in Year 2, and 55% of the project's total cost in Year 3 with non-Federal resources. The formula for calculating ADSSP-specific match is above.

Use of Funds: This program announcement will provide funds to develop, implement, and sustain an integrated system that offers a comprehensive set of high quality, evidence-based services that help persons with dementia and their family caregivers remain healthy and independent in the community. Applicants must demonstrate that the implementation of the cooperative agreement would: (a) establish new capacity or significantly enhance existing capacity; (b) does not duplicate existing work or supplant existing funding; and (c) devote all funding under the cooperative agreement to activities that implement the goals, objectives, and core components of the objectives under this program announcement.

3. Screening Criteria

Application Screening Criteria

All applications will be screened to assure a level playing field for all applicants. Applications that fail to meet the four screening criteria described below will **not** be reviewed and will receive **no** further consideration.

In order for an application to be reviewed, it must meet the following screening requirements:

1. Applications must be submitted electronically via http://www.grants.gov by 11:59 p.m., Eastern Time, **July 27, 2011**.

2. The Project Narrative section of the Application must be **double-spaced**, on 8 ½" x 11" plain white paper with **1" margins** on both sides, and a **font size of not less than 11**.

3. **The Project Narrative must not exceed 10 pages**. NOTE: The Project Work Plan, Letters of Commitment, and Vitae of Key Project Personnel **are not counted** as part of the Project Narrative for purposes of the 10-page limit.

4. Applicant must be a State Unit on Aging.

IV. APPLICATION AND SUBMISSION INFORMATION: PART B

1. Address to Request Application Package

Application materials can be obtained from http://www.grants.gov or http://www.aoa.gov/AoARoot/Grants/Funding/index.aspx.

Please note, AoA is requiring applications for all announcements to be submitted electronically through http://www.grants.gov. The Grants.gov (http://www.grants.gov) registration process can take several days. If your organization is not currently registered with http://www.grants.gov, please begin this process immediately. **For assistance with http://www.grants.gov, please contact them at** support@grants.gov **or 1-800-518-4726 between 7 a.m. and 9 p.m. Eastern Time.** At http://www.grants.gov, you will be able to download a copy of the application packet, complete it off-line, and then upload and submit the application via the Grants.gov website (http://www.grants.gov).

Applications submitted via http://www.grants.gov:

- You may access the electronic application for this program on http://www.grants.gov. You must search the downloadable application page by the Funding Opportunity Number (**HHS-2011-AoA-DS-1114)** or CFDA number 93.051.
- At the http://www.grants.gov website, you will find information about submitting an application electronically through the site, including the hours of operation. AoA strongly recommends that you do not wait until the application due date to begin the application process through http://www.grants.gov because of the time involved to complete the registration process.
- All applicants must have a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number and register in the Central Contractor

Registry (CCR). You should allow a minimum of **five days** to complete the CCR registration.

- Effective October 1, 2010, HHS requires all entities that plan to apply for and ultimately receive Federal grant funds from any HHS Operating/Staff Division (OPDIV/STAFFDIV) **or receive subawards directly from the recipients of those grant funds** to:
    1. Be registered in the CCR prior to submitting an application or plan;
    2. Maintain an active CCR registration with current information at all times during which it has an active award or an application or plan under consideration by an OPDIV; and
    3. Provide its DUNS umber in each application or plan it submits to the OPDIV.

  An award cannot be made until the applicant has complied with these requirements. At the time an award is ready to be made, if the intended recipient has not complied with these requirements, the OPDIV/STAFFDIV:
    - May determine that the applicant is not qualified to receive an award; and
    - May use that determination as a basis for making an award to another applicant.

  Additionally, all first-tier subaward recipients must have a DUNS number at the time the subaward is made.
- Since October 1, 2003, The Office of Management and Budget has required applicants to provide a Dun and Bradstreet (D&B) Data Universal Numbering System (DUNS) number when applying for Federal grants or cooperative agreements. It is entered on the SF 424. It is a unique, **nine-digit identification number**, which provides unique identifiers of single business entities. The DUNS number is *free and easy* to obtain.
- Organizations can receive a DUNS number at no cost by calling the dedicated toll-free DUNS Number request line at 1-866-705-5711 or by using this link to access a guide: http://www.whitehouse.gov/sites/default/files/omb/grants/duns_num_guide.pdf.
- You must submit all documents electronically, including all information included on the SF424 and all necessary assurances and certifications.
- Prior to application submission, Microsoft Vista and Office 2007 users should review the http://www.grants.gov compatibility information and submission instructions provided at http://www.grants.gov (click on "**Vista and Microsoft Office 2007 Compatibility Information**").
- **Your application must comply with any page limitation requirements described in this Program Announcement.**
- After you electronically submit your application, you will receive an automatic acknowledgement from http://www.grants.govthat contains http://www.grants.gov tracking number. The Administration on Aging will retrieve your application form from http://www.grants.gov.
- After the Administration on Aging retrieves your application form from http://www.grants.gov, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://www.grants.gov.
- Each year organizations registered to apply for Federal grants through http://www.grants.gov will need to renew their registration with the Central

Contractor Registry (CCR). You can register with the CCR online and it will take about 30 minutes (http://www.ccr.gov).

Contact person regarding this Program Announcement:

U.S. Department of Health and Human Services
Administration on Aging
Jane Tilly, DrPH
Center for Policy, Planning, and Evaluation
E-mail: jane.tilly@aoa.hhs.gov

2. Content and Form of Application Submission

a. Letter of Intent

Applicants are requested, but not required, to submit a letter of intent to apply for this program to assist AoA in planning for the application independent review process. The purpose of the letter of intent is to allow our staff to estimate the number of independent reviewers needed, to understand whether the applicant is applying for funding under Parts A and B of this Program Announcement, and to avoid potential conflicts of interest in the review. Note: The Assistant Secretary for Aging may give priority to those entities applying for both Parts A and B. The deadline for submission of the letter of intent is June 27, 2011. Letters of intent should be sent via email to:

Jane Tilly, DrPH
Center for Planning, Policy and Evaluation
Email: jane.tilly@aoa.hhs.gov

b. Project Narrative

The Project Narrative must be double-spaced, on 8 ½" x 11" paper with 1" margins on both sides, and a font size of not less than 11. You can use smaller font sizes to fill in the Standard Forms and Sample Formats. The suggested length for the Project Narrative is ten to fifteen pages; fifteen pages is the maximum length allowed. AoA will not accept applications with a Project Narrative that exceeds 10 pages. The Project Work Plan, Letters of Commitment, and Vitae of Key Personnel are not counted as part of the Project Narrative for purposes of the 15-page limit, but all of the other sections noted below are included in the limit.

The components of the Project Narrative counted as part of the 10 page limit include:

Summary/Abstract
Dementia Capability Assessment
Dementia Capability Objectives
Special Target Populations and Organizations

Outcomes
Dementia Capability Systems Project Management
Evaluation
Dissemination
Organizational Capability Statement

Please use each of these project components as headings in your narrative.

The Project Narrative is the most important part of the application, since it will be used as the primary basis to determine whether or not your project meets the minimum requirements for grants under the Public Health Services Act. The Project Narrative should provide a clear and concise description of your project. Your project narrative must include the following components:

Summary/Abstract. This section should include a brief - no more than 265 words maximum - description of the proposed project, including: goal(s), objectives, outcomes, and products to be developed. Detailed instructions for completing the summary/abstract are included in Attachment F of this document.

Dementia Capability Assessment: Minimum Requirements
Applicants must address **all** assessment issues in narrative format using the same headings and numerical sequence as laid out in this section**. If relevant information is provided in an appendix, you must specify the exact appendix location of that information**. This dementia capability assessment section should be no more than 8 double-spaced single-sided pages (documentation material to be located in indexed appendixes).

The purpose of this section is for the applicant to assess the state's readiness to implement the goals, objectives and their core components under this program announcement. Documentation must be provided to support statements made on each of the assessment issues presented below. Failure to provide documentation will result in a less than favorable score for the applicant. Examples of documentation may include legislation, regulations, memoranda of understanding/interagency agreements, letters of support from consumers, advocacy organizations and other stakeholders, state evaluation and research reports, agency progress reports, task force minutes, and data analyses.

1. Legislative and State Agency Leadership
Document the level of support for implementation of the goals, objectives and their core components under Part B of this program announcement from the various leaders in the state, and areas where consensus exists and where it is lacking among leaders. Include in this analysis the type and level of support specifically from the Governor, key legislative officials, the budget director, State Medicaid Director, and State Public Health Department Director, and other pertinent agency directors.

2. Stakeholder Support
Address the degree of interactive involvement and support of consumer/family/participant groups, local administering agencies and other pertinent entities. Areas of agreement and disagreement should be noted.

3. Progress with Meeting the Goals and Objectives of Part B of this Funding Opportunity Announcement

a. Document development of current system dementia capability.
b. Document the status of state or local agencies that include options counseling services, specifically noting those that have achieved fully functioning status for ADRCs (see definition in Attachment K).
c. Document the status of self directed services for persons with dementia and their family caregivers for all funding streams (Older Americans Act, Medicaid, state-funded programs) and the use of individual budgets.
d. Document the status of a robust quality assurance system for services.
e. Document the status of information technology that supports systems integration.
f. Document current level of state interagency and intra-agency collaboration by documenting progress and remaining challenges.
g. List all pertinent Alzheimer's Disease Supportive Services Program grants awarded to date with major goals achieved and not yet achieved.
h. Describe how you will overcome any current barriers to being able to hire readily state and/or contractual staff, as needed, to successfully carry out work on a system integration grant.
i. Document your state's history and ability to implement pilot projects and bring them to scale statewide.

The grant awards will be based upon review of the individual proposals and the accompanying budget documentation.

Dementia Capability Objectives.

Applicants' proposals must address in detail all the goals, objectives, and their core components under Part B of this Program Announcement. This dementia capability objectives section should be no more than 8 double-spaced single-sided pages (documentation material to be located in indexed appendixes).

The application must, for each of the two objectives and their core components (objectives 1 and 2 must have separate sections):

- Provide the underlying conceptual framework and methods that will be used to meet the objective.
- Discuss the strategies the applicant will use to achieve each of the objectives and its core components.
- Provide a summary of what the applicant will have accomplished at the end of the 12, 24 and 36 month cooperative agreement periods in achieving the two objectives and their core components. This summary must: identify which metrics the applicant would use to measure progress toward attaining these objectives. Applicants must use quantitative metrics to the extent possible.
- Describe the performance measures, indicators and data elements the applicant would voluntarily report to measure progress toward implementation of the two objectives and their core components.
- Describe the capacity and qualifications of key State and local staff to participate in the development, implementation and measurement of progress toward attainment of the goals, objectives and core components of the

objectives. Organizational charts and vitas will not count towards the narrative page limit.

Special Target Populations and Organizations. This section should describe how the applicant plans to involve community-based organizations in a meaningful way in the planning and implementation of the integrated systems project. This section should also describe how the proposed intervention will target underserved populations, including racial and ethnic minorities as well as limited-English speaking populations.

Outcomes. This section of the project narrative must clearly identify the measurable outcome(s) that will result from the integrated systems project. (NOTE: AoA will not fund any project that does not include measurable outcomes). This section should also describe how the project's findings might benefit the field at large, (e.g., how the findings could help other organizations throughout the nation to address the same or similar problems.) List measurable outcomes in the attached work plan grid (Attachment E) under "Measurable Outcomes" in addition to any discussion included in the narrative along with a description of how the project might benefit the field at large.

A "measurable outcome" is an observable end-result that describes how a particular intervention benefits consumers. It demonstrates the functional status, mental well-being, knowledge, skill, attitude, awareness or behavior. It can also describe a change in the degree to which consumers exercise choice over the types of services they receive, or whether they are satisfied with the way a service is delivered. Additional examples include: a change in the responsiveness or cost-effectiveness of a service delivery system; a new model of support or care that can be replicated in the aging network; new knowledge that can contribute to the field of aging; a measurable increase in community awareness; or a measurable increase in persons receiving services. A measurable outcome is not a measurable "output", such as: the number of clients served; the number of training sessions held; or the number of service units provided.

The applicant should keep the focus of this section on describing what outcome(s) will be produced by the dementia capability systems project. Applicants should use the Evaluation section noted below to describe how the outcome(s) will be measured and reported.

The application will be scored on the clarity and nature of the proposed outcomes, not on the number of outcomes cited.

Dementia Capability Systems Project Management. This section should include a clear delineation of the roles and responsibilities of project staff, consultants and partner organizations, and how they will contribute to achieving the project's objectives and outcomes. It should specify who would have day-to-day responsibility for key tasks such as: leadership of project; monitoring the project's on-going progress, preparation of reports; and communications with other partners and AoA. It should also describe the approach that will be used to monitor and track progress on the project's tasks and objectives.

Evaluation. This section should describe the method(s), techniques and tools that will be used to: 1) determine whether or not the proposed integrated systems project achieved its anticipated outcome(s), and 2) document the "lessons learned" – both positive and negative – from the project that will be useful to people interested in replicating it, if it proves successful.

Dissemination. This section should describe the method that will be used to disseminate the dementia capability system project's results and findings in a timely manner and in easily understandable formats, to parties who might be interested in using the results of the project to inform practice, service delivery, program development, and/or policy-making, including and especially those parties who would be interested in replicating the project.

Organizational Capability Statement. Each application should include an organizational capability statement and vitae for key project personnel. The organizational capability statement should describe how the applicant agency (or the particular division of a larger agency which will have responsibility for this project) is organized, the nature and scope of its work and/or the capabilities it possesses. It should also include the organization's capability to sustain some or all project activities after Federal financial assistance has ended. This description should cover capabilities of the applicant agency not included in the program narrative, such as any current or previous relevant experience and/or the record of the project team in preparing cogent and useful reports, publications, and other products. If appropriate, include an organization chart showing the relationship of the project to the current organization. Please attach short vitae for key project staff only. Neither vitas nor an organizational chart will count towards the narrative page limit. Also include information about any contractual organization(s) that will have a significant role(s) in implementing project and achieving project goals.

c. Work Plan

The Dementia Capable Systems Project Work Plan should reflect and be consistent with the Project Narrative and Budget and should cover all three (3) years of the project period. It should include a statement of the project's overall goal, anticipated outcome(s), key objectives, and the major tasks / action steps that will be pursued to achieve the goal and outcome(s). For each major task / action step, the work plan should identify timeframes involved (including start-and end-dates), and the lead person responsible for completing the task. Please use the Sample Work Plan format included in Attachment E. AoA projects at least 3 national meetings with grantees during the grant period. Applicants should plan and budget to send 3 representatives to each of these 3 national meetings.

d. Letters of Commitment from Key Participating Organizations and Agencies

Include confirmation of the commitments to the project (should it be funded) made by key collaborating organizations and agencies in this part of the application.

Any organization that is specifically named to have a significant role in carrying out the project should be considered an essential collaborator. For applications submitted electronically via http://*www.grants.gov*, signed letters of commitment should be scanned and included as attachments. Applicants unable to scan the signed letters of commitment may fax them to the AoA Office of Grants Management at 202-357-3467 by the application submission deadline. In your fax, be sure to include the program number and your agency name.

e. Budget Narrative/Justification

The Budget Narrative/Justification should be provided using the format included as Attachment C of this Program Announcement. Applicants are encouraged to pay particular attention to Attachment C, which provides an example of the level of detail sought. A combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding is required

3. Submission Dates and Times

The deadline for the submission of applications under this Program Announcement is July 27, 2011. Applications must be submitted electronically by 11:59 p.m. Eastern Time, July 27, 2011.

Applications that fail to meet the application due date will not be reviewed and will receive no further consideration. You are strongly encouraged to submit your application a minimum of 3-5 days prior to the application closing date. Do not wait until the last day in the event you encounter technical difficulties, either on your end or, with ***http://www.grants.gov***. Grants.gov can take up to 48 hours to notify you of a successful submission.

Unsuccessful submissions will require authenticated verification from ***http://www.grants.gov*** indicating system problems existed at the time of your submission. For example, you will be required to provide an ***http://www.grants.gov*** submission error notification and/or tracking number in order to substantiate missing the cut off date.

Grants.gov (http://*www.grants.gov*) will automatically send applicants a tracking number and date of receipt verification electronically once the application has been successfully received and validated in http://*www.grants.gov*. After AoA retrieves your application form from http://*www.grants.gov*, a return receipt will be emailed to the applicant contact. This will be in addition to the validation number provided by http://*www.grants.gov*.

4. Intergovernmental Review

This program announcement is not subject to the requirements of Executive Order 12372, "Intergovernmental Review of Federal Programs."

5. Funding Restrictions

The following activities are not fundable:

- Construction and/or major rehabilitation of buildings
- Basic research (e.g. scientific or medical experiments)
- Continuation of existing projects without expansion or new and innovative approaches.
- Pre-award costs

6. Other Submissions Requirements

Letters of intent should be emailed to:

Jane Tilly, DrPH
Email: jane.tilly@aoa.hhs.gov

V. APPLICATION REVIEW INFORMATION: PART B

1. Criteria

Applications are scored by assigning a maximum of 100 points across five criteria:

a. Project Relevance and Current Need (Dementia Capability Assessment) - (15 points);

b. Approach (Dementia Capability Objectives) - (20 points);

c. Budget – (10 points);

d. Project Impact - (35 points); and

e. Organizational Capacity - (20 points).

a. Project Relevance and Current Need (Dementia Capability Assessment)
Weight: 15 points

i. Does the proposed project clearly and adequately identify the relevance of the goals, objectives, and core components, as described in Part B of this Program Announcement, in relation to current state/community needs? (10 points).

ii. Does the application adequately and appropriately describe and document the key problem(s)/condition(s) and strengths of the current health, long-term services and supports, and related services systems relevant to the goals, objectives, and their core components, as described in Part B of this Program Announcement? Is

the proposed project justified in terms of the most recent, relevant, and available information and knowledge? (5 points)

b. Approach (Dementia Capability Objectives) Weight: 20 points

i. Is the dementia capability systems project clearly defined? Does it reflect a coherent and feasible approach for successfully achieving Part B of this Program Announcement's identified goals, objectives, and core components of the objectives? Does the project take into account barriers and opportunities that exist in the larger environment that may have an impact on the project's success? Does the proposal optimize the use of potential partnerships with other organizations and/or consumer groups, as required in Part B of this Program Announcement? (5 points)

ii. Is the project work plan clear and comprehensive? Does it include sensible and feasible timeframes for the accomplishment of Part B of this Program Announcement's goals, objectives, and core components of the objectives? Does the work plan include specific objectives and tasks that are linked to measurable outcomes? Does the proposal include a clear and coherent management plan? Are the roles and responsibilities of project staff, consultants and partners clearly defined and linked to Part B of this Program Announcement's identified goals, objectives, and core components of the objectives? (10 points)

iii. Does the application describe how local community-based organizations will be involved in a meaningful way in the planning and implementation of the proposed project? Does the application address the special needs of persons with dementia, persons with disabilities, their family caregivers, and underserved populations, such as racial or ethnic minorities as well as limited-English speaking populations, in its target population? (5 points)

c. Budget Weight: 10 points

i. Is the budget justified with respect to the adequacy and reasonableness of resources requested? Is the time commitment of the proposed director and other key project personnel sufficient to assure proper direction, management and timely completion of the project? (5 points)

ii. Are budget line items clearly delineated and consistent with work plan objectives? For example, has a multiyear budget covering the entire proposed project period been included as well as a budget covering each individual year? (5 points)

d. Project Impact Weight: 35 points

i. Are the expected project benefits/results clear, realistic, and consistent with Part B of this Program Announcement's goals, objectives and core components of the objectives, including the numbers/percentages of the population to be served? Are the anticipated outcomes of the proposed project likely to be achieved and will they significantly benefit the populations affected by the intervention, and the field of aging as a whole? Are the proposed outcomes quantifiable and measurable,

consistent with the definition of a project outcome contained in Part B of this Program Announcement?
(10 points)

ii. Does the project reflect a thoughtful and well-designed evaluation that will be able to successfully measure whether or not the project has achieved Part B of this Funding Announcement's goals, objectives, and core components of objectives? Does the plan include the qualitative and/or quantitative methods necessary to reliably measure outcomes? Is the evaluation designed to capture "lessons learned" from the overall effort that might be of use to others in the fields of aging and disability, especially those who might be interested in replicating the project? Has the applicant agreed to work with AoA and comply with any OMB approved reporting requirements? (10 points)

iii. Is there a realistic plan to ensure that resources are available to continue all project activities after Federal financial assistance has ended? (10 points)

iv. Will the dissemination plan get relevant and easy to use information in a timely manner to parties that might be interested in making use of its findings, particularly to those who might want to replicate the integrated systems project? (5 points)

e. Organizational Capacity **Weight: 20 points**

i. Does the applicant organization clearly identify its capacity for carrying out the proposed project and evaluation? Do key staff have time commitments allocated that are sufficient to carry out a project of this scope? (10 points)

ii. Do the proposed project director(s), key staff and consultants have the background, experience, and other qualifications required to carry out their designated roles? Are letters from participating organizations included, as appropriate, and do they express the clear commitment and areas of responsibility of those organizations, consistent with the work plan description of their intended roles and contributions? (10 points)

2. Review and Selection Process

An independent review panel of at least three individuals will evaluate applications that pass the screening and meet the responsiveness criteria if applicable. These reviewers are experts in their field, and are drawn from academic institutions, non-profit organizations, state and local government, and Federal government agencies. Based on the Application Review Criteria as outlined under section V.1, the reviewers will comment on and score the applications, focusing their comments and scoring decisions on the identified criteria.

Applicants have the option of omitting from the application copies (not the original) of specific salary rates or amounts for individuals specified in the application budget. Please do not include Social Security Numbers in your submission.

Final award decisions will be made by the Assistant Secretary for Aging (ASA). In making these decisions, the ASA will take into consideration: recommendations of the review panel; reviews for programmatic and grants management compliance; the reasonableness of the estimated cost to the government considering the available funding and anticipated results**;** the likelihood that the proposed project will result in the benefits expected**; and whether the applicant has applied for Parts A and B under this program announcement**.

3. Anticipated Announcement Award Date

Applicants can expect to learn about the disposition of their applications, whether successful or unsuccessful no later than September 30, 2011.

VI. AWARD ADMINISTRATION INFORMATION: PART B

1. Award Notices

Successful applicants will receive an electronic Notice of Award. The Notice of Award is the authorizing document from the U.S. Administration on Aging authorizing official, Officer of Grants Management, and the AoA Office of Budget and Finance. Unsuccessful applicants are generally notified within 30 days of the final funding decision and will receive a disapproval letter via e-mail or U.S. mail. Unless indicated otherwise in this announcement, unsuccessful applications will not be retained by the agency and destroyed.

2. Administrative and National Policy Requirements

The award is subject to DHHS Administrative Requirements, which can be found in 45CFR Part 74 and 92 and the Standard Terms and Conditions implemented through the HHS Grants Policy Statement located at *http://www.hhs.gov/grantsnet/adminis/gpd/index.htm*.

3. Reporting

Effective March 1, 2011, AoA requires the submission of the SF-425 (Federal Financial Report). The AoA program progress report is due semi-annually from the start date of the award. Final performance and SF-425 reports are due 90 days after the end of the project period.

Grantees are required to complete the federal cash transactions portion of the SF-425 within the Payment Managements System as identified in their award documents for the calendar quarters ending 3/31, 6/30, 9/30, and 12/31 through the life of their award. In addition, the fully completed SF-425 will be required as denoted in the Notice of Award terms and conditions.

4. FFATA and FSRS Reporting

The Federal Financial Accountability and Transparency Act (FFATA) requires data entry at the FFATA Subaward Reporting System (http://www.FSRS.gov) for all sub-awards and sub-contracts issued for $25,000 or more as well as addressing executive compensation for both grantee and sub-award organizations.

For further guidance please see the following link:
http://www.aoa.gov/aoaroot/grants/ARRA_Terms/docs/Requirements_for_FFATA.pdf

VII. AGENCY CONTACTS: PART B

Project Officer:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Jane Tilly
E-mail: jane.tilly@aoa.hhs.gov

Grants Management Specialist:
U.S. Department of Health and Human Services
Administration on Aging
Washington, DC 20201
Attn: Rebecca Mann
e-mail: Rebecca.mann@aoa.hhs.gov

VIII. OTHER INFORMATION: PART B

1. Application Elements

a. SF 424 – Application for Federal Assistance (See Attachment A for Instructions).

b. SF 424A – Budget Information. (See Attachment A for Instructions; See Attachment B for an example of a completed SF 424A).

c. Separate Budget Narrative/Justification (See Attachment C for a Budget Narrative/Justification Sample Format with Examples and Attachment D for a Sample Template).
NOTE: Applicants requesting funding for multi-year grant projects are REQUIRED to provide a Narrative/Justification for each year of potential grant funding, as well as a combined multi-year detailed Budget Narrative/Justification.

d. SF 424B – Assurances. Note: Be sure to complete this form according to instructions and have it signed and dated by the authorized representative (see item 18d on the SF 424).

e. Lobbying Certification

f. Proof of non-profit status, if applicable

g. Copy of the applicant's most recent indirect cost agreement, if requesting indirect costs. If any sub-contractors or sub-grantees are requesting indirect costs, copies of their indirect cost agreements must also be included with the application.

h. Project Narrative with Work Plan (See Attachment E, for Sample Work Plan Format).

i. Organizational Capability Statement and Vitae for Key Project Personnel.

j. Letters of Commitment from Key Partners, if applicable.

2. The Paperwork Reduction Act of 1995 (P.L. 104-13)

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The project description and Budget Narrative/Justification is approved under OMB control number 0985-0018 which expires on 8/31/13. Public reporting burden for this collection of information is estimated to average 10 hours per response, including the time for reviewing instructions, gathering and maintaining the data needed and reviewing the collection information.

ATTACHMENTS

Attachment A:
Instructions for Completing Required Forms
(SF 424, Budget (SF 424A), Budget Narrative/Justification)

Attachment B:
SF 424 – Sample Format with Example

Attachment C:
Budget Narrative/Justification Format – Sample Format with Examples

Attachment D:
Budget Narrative/Justification – Sample Template

Attachment E:
Project Work Plan - Sample Template

Attachment F:
Instructions for Completing the Summary/Abstract

Attachment G:
Definitions

Attachment H:
Alzheimer's Disease Supporting Services Program Requirements

Attachment I:
AoA-Sponsored Resource Centers

Attachment J:
Programs and Initiatives

Attachment K:
Fully Functioning Aging and Disability Resource Centers

Attachment A: Instructions for Completing Required Forms

(SF 424, Budget (SF 424A), Budget Narrative/Justification)

This section provides step-by-step instructions for completing the four (4) standard Federal forms required as part of your grant application, including special instructions for completing Standard Budget Forms 424 and 424A. Standard Forms 424 and 424A are used for a wide variety of Federal grant programs, and Federal agencies have the discretion to require some or all of the information on these forms. AoA does not require all the information on these Standard Forms. Accordingly, please use the instructions below in lieu of the standard instructions attached to SF 424 and 424A to complete these forms.

a. Standard Form 424

1. **Type of Submission:** (REQUIRED): Select one type of submission in accordance with agency instructions.

- Preapplication
- Application
- Changed/Corrected Application – If AoA requests, check if this submission is to change or correct a previously submitted application.

2. **Type of Application**: (REQUIRED) Select one type of application in accordance with agency instructions.

- New
- Continuation
- Revision

3. **Date Received:** Leave this field blank.

4. **Applicant Identifier**: Leave this field blank

5a **Federal Entity Identifier**: Leave this field blank

5b. **Federal Award Identifier**: For new applications leave blank. For a continuation or revision to an existing award, enter the previously assigned Federal award (grant) number.

6. **Date Received by State:** Leave this field blank.

7. **State Application Identifier:** Leave this field blank.

8. **Applicant Information**: Enter the following in accordance with agency instructions:

a. Legal Name: (REQUIRED): Enter the name that the organization has registered with the Central Contractor Registry. Information on registering with CCR may be obtained by visiting the Grants.gov website (http://www.grants.gov).

b. Employer/Taxpayer Number (EIN/TIN): (REQUIRED): Enter the Employer or Taxpayer Identification Number (EIN or TIN) as assigned by the Internal Revenue Service.

c. Organizational DUNS: (REQUIRED) Enter the organization's DUNS or DUNS+4 number received from Dun and Bradstreet. Information on obtaining a DUNS number may be obtained by visiting the Grants.gov website (http://www.grants.gov). Your DUNS number can be verified at http://www2.zapdata.com/CompanyLookup.do.

d. Address: (REQUIRED) Enter the complete address including the county.

e. Organizational Unit: Enter the name of the primary organizational unit (and department or division, if applicable**)** that will undertake the project.

f. Name and contact information of person to be contacted on matters involving this application: Enter the name (First and last name required), organizational affiliation (if affiliated with an organization other than the applicant organization), telephone number (Required), fax number, and email address (Required) of the person to contact on matters related to this application.

9. **Type of Applicant:** (REQUIRED) Select the applicant organization "type" from the following drop down list.
A. State Government B. County Government C. City or Township Government D. Special District Government E. Regional Organization F. U.S. Territory or Possession G. Independent School District H. Public/State Controlled Institution of Higher Education I. Indian/Native American Tribal Government (Federally Recognized) J. Indian/Native American Tribal Government (Other than Federally Recognized) K. Indian/Native American Tribally Designated Organization L. Public/Indian Housing Authority M. Nonprofit with 501C3 IRS Status (Other than Institution of Higher Education) N. Nonprofit without 501C3 IRS Status (Other than Institution of Higher Education) O. Private Institution of Higher Education P. Individual Q. For-Profit Organization (Other than Small Business) R. Small Business S. Hispanic-serving Institution T. Historically Black Colleges and Universities (HBCUs) U. Tribally Controlled Colleges and Universities (TCCUs) V. Alaska Native and Native Hawaiian Serving Institutions W. Non-domestic (non-US) Entity X. Other (specify)

10. **Name Of Federal Agency**: (REQUIRED) Enter U.S. Administration on Aging

11. **Catalog Of Federal Domestic Assistance Number/Title:** The CFDA number can be found on page one of the Program Announcement.

12. **Funding Opportunity Number/Title:** (REQUIRED) The Funding Opportunity Number and title of the opportunity can be found on page one of the Program Announcement.

13. **Competition Identification Number/Title:** Leave this field blank.

14. **Areas Affected By Project:** List the largest political entity affected (cities, counties, state etc).

15. **Descriptive Title of Applicant's Project:** (REQUIRED) Enter a brief descriptive title of the project.

16. **Congressional Districts Of**: (REQUIRED) 16a. Enter the applicant's Congressional District, and 16b. Enter all district(s) affected by the program or project. Enter in the format: 2 characters State Abbreviation – 3 characters District Number, e.g., CA-005 for California 5th district, CA-012 for California 12th district, NC-103 for North Carolina's 103rd district. If all congressional districts in a state are affected, enter "all" for the district number, e.g., MD-all for all congressional districts in Maryland. If nationwide, i.e. all districts within all states are affected, enter US-all. See the below website to find your congressional district:

http://www.house.gov/Welcome.shtml

17. **Proposed Project Start and End Dates**: (REQUIRED) Enter the proposed start date and final end date of the project**. If you are applying for a multi-year grant, such as a 3 year grant project, the final project end date will be 3 years after the proposed start date.** In general, all start dates on the SF424 should be the 1st of the month and the end date of the last day of the month of the final year, for example 4/01/2011 to 3/31/2014. The Grants Officer can alter the start and end date at their discretion.

18. **Estimated Funding:** (REQUIRED) If requesting multi-year funding, enter the full amount requested from the Federal Government in line item 18.a., as a multi-year total. For example and illustrative purposes only, if year one is $100,000, year two is $100,000, and year three is $100,000, then the full amount of Federal funds requested would be reflected as $300,000. The amount of matching funds is denoted by lines b. through f. with a combined Federal and non-Federal total entered on line g. Lines b. through f. represents contributions to the project by the applicant and by your partners during the total project period, broken down by each type of contributor. The value of in-kind contributions should be included on appropriate lines, as applicable.

NOTE: Applicants should review cost sharing or matching principles contained in Subpart C of 45 CFR Part 74 or 45 CFR Part 92 before completing Item 18 and the Budget Information Sections A, B and C noted below.

All budget information entered under item 18 should cover the total project period. For sub-item 18a, enter the Federal funds being requested. Sub-items 18b-18e is considered matching funds. The dollar amounts entered in sub-items 18b-18f must total at least 1/3rd of the amount of Federal funds being requested (the amount in 18a). For a full explanation of AoA's match requirements, see the information in the box below. For sub-item 18f (program income), enter only the amount, if any, that is going to be used as part of the required match. Program Income submitted as match will become a part of the award match and recipients will be held accountable to meet their share of project expenses even if program income is not generated during the award period.

There are two types of match: 1) non-Federal cash and 2) non-Federal in-kind. In general, costs borne by the applicant and cash contributions of any and all third parties involved in the project, including sub-grantees, contractors and consultants, are considered **matching funds**. Examples of **non-Federal cash match** includes budgetary funds provided from the applicant agency's budget for costs associated with the project. Generally, most contributions from sub-contractors or sub-grantees (third parties) will be non-Federal in-

kind matching funds. Volunteered time and use of facilities to hold meetings or conduct project activities may be considered in-kind (third party) donations.

NOTE: **Indirect charges** may only be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency; or (2) the applicant is a state or local government agency. State governments should enter the amount of indirect costs determined in accordance with DHHS requirements. **If indirect costs are to be included in the application, a copy of the approved indirect cost agreement must be included with the application. Further, if any sub-contractors or sub-grantees are requesting indirect costs, a copy of the latest approved indirect cost agreements must also be included with the application, or reference to an approved cost allocation plan.**

19. **Is Application Subject to Review by State Under Executive Order 12372 Process?** Check c. Program is not covered by E.O. 12372

20. **Is the Applicant Delinquent on any Federal Debt?** (Required) This question applies to the applicant organization, not the person who signs as the authorized representative. If yes, include an explanation on the continuation sheet.

21. **Authorized Representative**: (Required) To be signed and dated by the authorized representative of the applicant organization. Enter the name (First and last name required) title (Required), telephone number (Required), fax number, and email address (Required) of the person authorized to sign for the applicant. A copy of the governing body's authorization for you to sign this application as the official representative must be on file in the applicant's office. (Certain Federal agencies may require that this authorization be submitted as part of the application.)

b. Standard Form 424A

NOTE: Standard Form 424A is designed to accommodate applications for multiple grant programs; thus, for purposes of this AoA program, many of the budget item columns and rows are not applicable. You should only consider and respond to the budget items for which guidance is provided below. Unless otherwise indicated, the SF 424A should reflect a multi year budget. See Attachment B.

Section A - Budget Summary

Line 5: Leave columns (c) and (d) blank. Enter TOTAL Federal costs in column (e) and total non-Federal costs (including third party in-kind contributions and any program income to be used as part of the grantee match) in column (f). Enter the sum of columns (e) and (f) in column (g).

Section B - Budget Categories

Column 1: Enter the breakdown of how you plan to use the Federal funds being

requested by object class category (see instructions for each object class category in Attachment C).

Column 2: Enter the breakdown of how you plan to use the non-Federal share by object class category.

Column 5: Enter the total funds required for the project (sum of Columns 1 and 2) by object class category.

Section C – Non Federal Resources

Column A: Enter the federal grant program.

Column B: Enter in any non-federal resources that the applicant will contribute to the project.

Column C: Enter in any non-federal resources that the state will contribute to the project.

Column D: Enter in any non-federal resources that other sources will contribute to the project.

Column E: Enter the total non-federal resources for each program listed in column A.

Section D –Forecasted Cash Needs

Line 13: Enter Federal forecasted cash needs broken down by quarter for the first year only.

Line 14: Enter Non-Federal forecasted cash needs broken down by quarter for the first year.

Line 15: Enter total forecasted cash needs broken down by quarter for the first year.

Note: This area is not meant to be one whereby an applicant merely divides the requested funding by four and inserts that amount in each quarter but an area where thought is given as to how your estimated expenses will be incurred during each quarter. For example, if you have initial start up costs in the first quarter of your award reflect that in quarter one or you do not expect to have contracts awarded and funded until quarter three, reflect those costs in that quarter.

Section E – Budget Estimates of Federal Funds Needed for Balance of the Project (i.e. subsequent years 2, 3, 4 or 5 as applicable).

Column A: Enter the federal grant program

Column B (first): Enter the requested year two funding.

Column C (second): Enter the requested year three funding.

Column D (third): Enter the requested year four funding, if applicable.

Column E (forth): Enter the requested year five funding, if applicable.

Section F – Other Budget Information

Line 21: Enter the total Indirect Charges

Line 22: Enter the total Direct charges (calculation of indirect rate and direct charges).

Line 23: Enter any pertinent remarks related to the budget.

Separate Budget Narrative/Justification Requirement

Applicants requesting funding for multi-year grant programs are REQUIRED to provide a combined multi-year Budget Narrative/Justification, as well as a detailed Budget Narrative/Justification for each year of potential grant funding. A separate Budget Narrative/Justification is also REQUIRED for each potential year of grant funding requested.

For your use in developing and presenting your Budget Narrative/Justification, a sample format with examples and a blank sample template have been included in these Attachments. In your Budget Narrative/Justification, you should include a breakdown of the budgetary costs for all of the object class categories noted in Section B, across three columns: Federal; non-Federal cash; and non-Federal in-kind. Cost breakdowns, or justifications, are required for any cost of $1,000 or for the thresholds as established in the examples. The Budget Narratives/Justifications should fully explain and justify the costs in each of the major budget items for each of the object class categories, as described below. Non-Federal cash as well as, sub-contractor or sub-grantee (third party) in-kind contributions designated as match must be clearly identified and explained in the Budget Narrative/Justification The full Budget Narrative/Justification should be included in the application immediately following the SF 424 forms.

Line 6a: **Personnel**: Enter total costs of salaries and wages of applicant/grantee staff. Do not include the costs of consultants, which should be included under 6h - Other.
In the Justification: Identify the project director, if known. Specify the key staff, their titles, and time commitments in the budget justification.

Line 6b: **Fringe Benefits**: Enter the total costs of fringe benefits unless treated as part of an approved indirect cost rate.
In the Justification: If the total fringe benefit rate exceeds 35% of Personnel costs, provide a break-down of amounts and percentages that comprise fringe benefit costs, such as health insurance, FICA, retirement, etc. A percentage of 35% or less does not require a break down but you must show the percentage charged for each full/part time employee.

Line 6c: **Travel**: Enter total costs of all travel (local and non-local) for staff on the project. NEW: Local travel is considered under this cost item not under Other. Local transportation (all travel which does not require per diem is considered local travel). Do not enter costs for consultant's travel - this should be included in line 6h.
In the Justification: Include the total number of trips, number of travelers, destinations, purpose (e.g., attend conference), length of stay, subsistence allowances (per diem), and transportation costs (including mileage rates).

Line 6d: **Equipment**: Enter the total costs of all equipment to be acquired by the project. For all grantees, "equipment" is non-expendable tangible personal property

having a useful life of more than one year and an acquisition cost of $5,000 or more per unit. If the item does not meet the $5,000 threshold, include it in your budget under Supplies, line 6e.

In the Justification: Equipment to be purchased with federal funds must be justified as necessary for the conduct of the project. The equipment must be used for project-related functions. Further, the purchase of specific items of equipment should not be included in the submitted budget if those items of equipment, or a reasonable facsimile, are otherwise available to the applicant or its sub-grantees.

Line 6e: **Supplies**: Enter the total costs of all tangible expendable personal property (supplies) other than those included on line 6d.

In the Justification: For any grant award that has supply costs in excess of 5% of total direct costs (Federal or Non-Federal), you must provide a detailed break down of the supply items (e.g., 6% of $100,000 = $6,000 – breakdown of supplies needed). If the 5% is applied against $1 million total direct costs (5% x $1,000,000 = $50,000) a detailed breakdown of supplies is not needed. Please note: any supply costs of $5,000 or less regardless of total direct costs does not require a detailed budget breakdown (e.g., 5% x $100,000 = $5,000 – no breakdown needed).

Line 6f: **Contractual**: Regardless of the dollar value of any contract, you must follow your established policies and procedures for procurements and meet the minimum standards established in the Code of Federal Regulations (CFR's) mentioned below. Enter the total costs of all contracts, including (1) procurement contracts (except those which belong on other lines such as equipment, supplies, etc.). Note: The 33% provision has been removed and line item budget detail is not required as long as you meet the established procurement standards. Also include any awards to organizations for the provision of technical assistance. Do not include payments to individuals on this line. Please be advised: A subrecipient is involved in financial assistance activities by receiving a sub-award and a subcontractor is involved in procurement activities by receiving a sub-contract. Through the recipient, a subrecipient performs work to accomplish the public purpose authorized by law. Generally speaking, a sub-contractor does not seek to accomplish a public benefit and does not perform substantive work on the project. It is merely a vendor providing goods or services to directly benefit the recipient, for example procuring landscaping or janitorial services. In either case, you are encouraged to clearly describe the type of work that will be accomplished and type of relationship with the lower tiered entity whether it be labeled as a subaward or subcontract.

In the Justification: Provide the following three items – 1) Attach a list of contractors indicating the name of the organization; 2) the purpose of the contract; and 3) the estimated dollar amount. If the name of the contractor and estimated costs are not available or have not been negotiated, indicate when this information will be available. The Federal government reserves the right to request the final executed contracts at any time. If an individual contractual item is over the small purchase threshold, currently set at $100K in the CFR, you must certify that your procurement standards are in accordance with the policies and procedures as stated in 45 CFR 74.44 for non-profits and 92.36 for states, in lieu

of providing separate detailed budgets. This certification should be referenced in the justification and attached to the budget narrative.

Line 6g: **Construction**: Leave blank since construction is not an allowable costs for this program.

Line 6h: **Other**: Enter the total of all other costs. Such costs, where applicable, may include, but are not limited to: insurance, medical and dental costs (i.e. for project volunteers this is different from personnel fringe benefits),non-contractual fees and travel paid directly to *individual* consultants, postage, space and equipment rentals/lease, printing and publication, computer use, training and staff development costs (i.e. registration fees). If a cost does not clearly fit under another category, and it qualifies as an allowable cost, then rest assured this is where it belongs.

In the Justification: Provide a reasonable explanation for items in this category. For example, individual consultants explain the nature of services provided and the relation to activities in the work plan or indicate where it is described in the work plan. Describe the types of activities for staff development costs.

Line 6i: **Total Direct Charges**: Show the totals of Lines 6a through 6h.

Line 6j: **Indirect Charges**: Enter the total amount of indirect charges (costs), if any. If no indirect costs are requested, enter "none." Indirect charges may be requested if: (1) the applicant has a current indirect cost rate agreement approved by the Department of Health and Human Services or another federal agency; or (2) the applicant is a state or local government agency. **State governments should enter the amount of indirect costs determined in accordance with DHHS requirements.** An applicant that will charge indirect costs to the grant must enclose a copy of the current rate agreement. Indirect Costs can only be claimed on Federal funds, more specifically, they are to only be claimed on the Federal share of your direct costs. Any unused portion of the grantee's eligible Indirect Cost amount that are not claimed on the Federal share of direct charges can be claimed as un-reimbursed indirect charges, and that portion can be used towards meeting the recipient match.

Line 6k: **Total**: Enter the total amounts of Lines 6i and 6j.

Line 7: **Program Income**: As appropriate, include the estimated amount of income, if any, you expect to be generated from this project that you wish to designate as match (equal to the amount shown for Item 15(f) on Form 424). **Note:** Any program income indicated at the bottom of Section B and for item 15(f) on the face sheet of Form 424 will be included as part of non-Federal match and will be subject to the rules for documenting completion of this pledge. If program income is expected, but is not needed to achieve matching funds, **do not** include that portion here or on Item 15(f) of the Form 424 face sheet. Any anticipated program income that will not be applied as grantee match should be described in the Level of Effort section of the Program Narrative.

c. Standard Form 424B - Assurances

This form contains assurances required of applicants under the discretionary funds programs administered by the Administration on Aging. Please note that a duly authorized representative of the applicant organization must certify that the organization is in compliance with these assurances.

d. Certification Regarding Lobbying

This form contains certifications that are required of the applicant organization regarding lobbying. Please note that a duly authorized representative of the applicant organization must attest to the applicant's compliance with these certifications.

Proof of Non-Profit Status

Non-profit applicants must submit proof of non-profit status. Any of the following constitutes acceptable proof of such status:

- A copy of a currently valid IRS tax exemption certificate.
- A statement from a State taxing body, State attorney general, or other appropriate State official certifying that the applicant organization has a non-profit status and that none of the net earnings accrue to any private shareholders or individuals.
- A certified copy of the organization's certificate of incorporation or similar document that clearly establishes non-profit status.

Indirect Cost Agreement

Applicants that have included indirect costs in their budgets must include a copy of the current indirect cost rate agreement approved by the Department of Health and Human Services or another Federal agency. This is optional for applicants that have not included indirect costs in their budgets.

Attachment B: Standard Form 424A – Sample Format

OMB Approval No. 0348-0044

BUDGET INFORMATION--Non-Construction Programs

SECTION A-BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. LifeSpan Respite	93.048			300,000	100,000	400,000
2.						
3.						
4.						
5. **TOTALS**				300,000	100,000	400,000

SECTION B-BUDGET CATEGORIES

6. **Object Class Categories**	GRANT PROGRAM, FUNCTION OR ACTIVITY				**Total** (5)
	(1) Year 1	(2) Year 2	(3) Year 3	(4)	
a. **Personnel**	25,000	30,000	35,000		90,000
b. **Fringe Benefits**	10,000	15,000	20,000		45,000
c. **Travel**	5,000	5,000	5,000		15,000
d. **Equipment**	5,000	0	0		5,000
e. **Supplies**	5,000	2,500	1,000		8,500
f. **Contractual**	15,000	0	0		15,000
g. **Construction**	0	0	0		
h. **Other**	43,333	55,833	47,334		146,500
i. **Total Direct Charges** (sum 6a-h)	75,000	75,000	75,000		225,000
j. **Indirect Charges** @	25,000	25,000	25,000		75,000
k. **TOTALS** (sum 6i and j)	133,333	133,333	133,334		400,000
7. **Program Income**	None				

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SECTION C-NON-FEDERAL RESOURCES				
(a) Grant Program	(b) Applicant	(c) State	(d) Other sources	(e) TOTALS
8. Life Span Respite	60,000	30,000	10,000	100,000
9.				
10.				
11.				
12. **TOTALS** (sum of lines 8 and 11)	60,000	30,000	10,000	100,000

SECTION D-FORECASTED CASH NEEDS					
13. **Federal**	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
	100,000	15,000	50,000	20,000	15,000
14. **Non-Federal**	33,333	6,000	10,000	9,000	8,333
15. **TOTAL** (sum of lines 13 and 14)					

SECTION E-BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT				
(a) Grant Program	Future Funding Periods (Years)			
	(b) First	(c) Second	(d)	(e)
16. Life Span Respite	100,000	100,000		
17.				
18.				
19.				
20. **TOTALS** (sum of lines 16-19)				

SECTION F-OTHER BUDGET INFORMATION (Attach additional Sheets if Necessary)	
21. **Direct Charges:**	22. **Indirect Charges:**
23. **Remarks**	

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Attachment C: Budget Narrative/Justification – Sample Format

NOTE: Applicants requesting funding for a multi-year grant program are REQUIRED to provide a detailed Budget Narrative/Justification for EACH potential year of grant funding requested.

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel	$47,700	$23,554	$0	$71,254	**Federal** Project Director (name) = .5 FTE @ $95,401/yr = $47,700 **Non-Fed Cash** Officer Manager (name) = .5FTE @ $47,108/yr = $23,554 Total $71,254
Fringe Benefits	$17,482	$8,632	$0	$26,114	**Federal** Fringe on Project Director at 36.65% = $17,482 FICA (7.65%) Health (25%) Dental (2%) Life (1%) Unemployment (1%) **Non-Fed Cash** Fringe on Office Manager at 36.65% = $8,632 FICA (7.65%) Health (25%) Dental (2%) Life (1%) Unemployment (1%)

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Travel	$4,707	$2,940	$0	$7,647	**Federal** Local travel: 6 TA site visits for 1 person Mileage: 6RT @ .585 x 700 miles $2,457 Lodging: 15 days @ $110/day $1,650 Per Diem: 15 days @ $40/day $600 Total $4,707 **Non-Fed Cash** Travel to National Conference in (Destination) for 3 people Airfare 1 RT x 3 staff @ $500 $1,500 Lodging: 3 days x 3 staff @ $120/day $1,080 Per Diem: 3 days x 3 staff @ $40/day $360 Total $2,940
Equipment	$10,000	$0	$0	$10,000	*No Equipment requested OR:* Call Center Equipment Installation = $5,000 Phones = $5,000 Total $10,000
Supplies	$3,700	$5,784	$0	$9,484	**Federal** 2 desks @ $1,500 $3,000 2 chairs @ $300 $600 2 cabinets @ $200 $400 **Non-Fed Cash** 2 Laptop computers $3,000 Printer cartridges @ $50/month $300 Consumable supplies (pens, paper, clips etc…) @ $182/month $2,184 Total $9,484

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Contractual	$30,171	$0	$0	$30,171	(organization name, purpose of contract and estimated dollar amount) Contract with AAA to provide respite services: 11 care givers @ $1,682 = $18,502 Volunteer Coordinator = $11,669 Total $30,171 *If contract details are unknown due to contract yet to be made provide same information listed above and:* A detailed evaluation plan and budget will be submitted by (date), when contract is made.
Other	$5,600	$0	$5,880	$11,480	**Federal** 2 consultants @ $100/hr for 24.5 hours each = $4,900 Printing 10,000 Brochures @ $.05 = $500 Local conference registration fee (name conference) = $200 Total $5,600 **In-Kind** **Volunteers** 15 volunteers @ $8/hr for 49 hours = $5,880
Indirect Charges	$20,934	$0	$0	$20,934	21.5 % of salaries and fringe = $20,934 IDC rate is attached.
TOTAL	$140,294	$40,910	$5,880	$187,084	

Attachment D: Budget Narrative/Justification — Sample Template

NOTE: Applicants requesting funding for a multi-year grant program are REQUIRED to provide a detailed Budget Narrative/Justification for EACH potential year of grant funding requested.

Object Class Category	Federal Funds	Non-Federal Cash	Non-Federal In-Kind	TOTAL	Justification
Personnel					
Fringe Benefits					
Travel					
Equipment					
Supplies					
Contractual					
Other					
Indirect Charges					
TOTAL					

Attachment E: Project Work Plan – Sample Template

NOTE: Applicants requesting funding for a multi-year grant program are REQUIRED to provide a Project Work Plan for EACH potential year of grant funding requested.

Goal:
Measurable Outcome(s):

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	Lead Person	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
1.														
2.														

Attachment E: Project Work Plan, Page 2 – Sample Template

Goal:
Measurable Outcome(s):

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	Lead Person	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
3.														
4.														

Attachment E: Project Work Plan, Page 3 – Sample Template

Goal:
Measurable Outcome(s):

* **Time Frame** (Start/End Dates by Month in Project Cycle)

Major Objectives	Key Tasks	Lead Person	1*	2*	3*	4*	5*	6*	7*	8*	9*	10*	11*	12*
5.														
6.														

NOTE: Please do note infer from this sample format that your work plan must have 6 major objectives. If you need more pages, simply repeat this format on additional pages.

Attachment F: Instructions for Completing the Project Summary/Abstract

- All applications for grant funding must include a Summary/Abstract that concisely describes the proposed project. It should be written for the general public.
- To ensure uniformity, limit the length to 265 words or less, on a single page with a font size of not less than 11, doubled-spaced.
- The abstract must include the project's goal(s), objectives, overall approach (including target population and significant partnerships), anticipated outcomes, products, and duration. The following are very simple descriptions of these terms, and a sample Compendium abstract.

  Goal(s) – broad, overall purpose, usually in a mission statement, i.e. what you want to do, where you want to be.

  Objective(s) – narrow, more specific, identifiable or measurable steps toward a goal. Part of the planning process or sequence (the "how") to attain the goal(s).

  Outcomes - measurable results of a project. Positive benefits or negative changes, or measurable characteristics that occur as a result of an organization's or program's activities. (Outcomes are the end-point)

  Products – materials, deliverables.

A model abstract/summary is provided below:

The Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD), in **partnership** with the Delaware Lifespan Respite Care Network (DLRCN) and key stakeholders will, in the course of this two-year project, expand and maintain a statewide coordinated lifespan respite system that builds on the infrastructure currently in place. The **goal** of this project is to improve the delivery and quality of respite services available to families across age and disability spectrums by expanding and coordinating existing respite systems in Delaware. The **objectives** are: 1) to improve lifespan respite infrastructure; 2) to improve the provision of information and awareness about respite service; 3) to streamline access to respite services through the Delaware ADRC; 4) to increase availability of respite services. Anticipated **outcomes** include: 1) families and caregivers of all ages and disabilities will have greater options for choosing a respite provider; 2) providers will demonstrate increased ability to provide specialized respite care; 3) families will have streamlined access to information and satisfaction with respite services; 4) respite care will be provided using a variety of existing funding sources and 5) a sustainability plan will be developed to support the project in the future. The expected **products** are marketing and outreach materials, caregiver training, respite worker training, a Respite Online searchable database, two new Caregiver Resource Centers (CRC), an annual Respite Summit, a respite voucher program and 24/7 telephone information and referral services.

Attachment G: Definitions

Benefits Counseling is the provision of information and assistance designed to help people learn about and, if desired, apply for public and private benefits to which they are entitled, including but not limited to, private insurance (such as Medicare Supplemental Insurance policies), Supplemental Security Income (SSI), Food Stamps, Medicare, Medicaid and private pension benefits. For purposes of this program announcement, benefits counseling funded under the Older Americans Act that is provided to individuals who need help to remain in the community, is included in this definition.

Care Transitions is a person-centered, interdisciplinary approach to integrating health care and social support services for individuals and their caregivers as they move across settings in which individual needs and preferences are identified, comprehensive service plans are developed and activated, individuals are empowered to take an active role in their health care, and support and connection to resources are provided by options counselors and/or identified care transition staff.

Centers for Independent Living (CIL): (1) Center for independent living. The term "center for independent living" means a consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that – (A) is designed and operated within a local community by individuals with disabilities; and (B) provides an array of independent living services such as information and referral, peer counseling, advocacy, and independent living skills training.
(2) Consumer control. The term "consumer control" means, with respect to a center for independent living, that the center vests power and authority in individuals with disabilities.

Dementia-capable: Means tailored to the unique needs of persons with dementia stemming from conditions such as Alzheimer's disease and related disorders, and their caregivers. For example:

- Information and assistance should identify those with dementia.
- Options counseling staff should understand how best to communicate with persons with dementia and their family caregivers.
- The services to which persons with dementia are referred should meet their unique needs. For example, persons with dementias, such as Alzheimer's disease, must have access to "dementia capable" providers who deliver services that are tailored to their needs. Effective interventions begin at the earliest stages of the disease, although most community-based programs are focused on the middle stages when families are already in crisis.
- Self directed services should: ensure that persons with dementia are supported in their decision-making about services and involve family caregivers when necessary.

Disability: As defined by the American's with Disability Act Statutory Definition -- With respect to an individual, the term "disability" means (A) a physical or mental impairment

that substantially limits one or more of the major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment. 42 U.S.C. § 12102(2); see also 29 C.F.R. § 1630.2(g). A person must meet the requirements of at least one of these three criteria to be an individual with a disability under the Act.

Eligibility Screening: Is a non-binding inquiry into an individual's income and assets, as necessary, and other circumstances in order to determine probable eligibility for programs, services, and benefits, including Medicaid. This screening should be provided to all individuals who may be eligible for publicly funded programs.

Evidence-based programs or interventions have been tested through randomized controlled trials and are: 1) effective at improving, maintaining, or slowing the decline in the health or functional status of older people; 2) suitable for deployment through community-based human services organizations and involve non-clinical workers and/or volunteers in the delivery of the intervention; 3) the research results have been published in a peer-reviewed scientific journal; and 4) the intervention has been translated into practice and is ready for distribution through community-based human services organizations.

Evidence-informed interventions have substantive research evidence that demonstrates an ability to improve, maintain, or slow the decline in the health and functional status of older people. For the purposes of this announcement, evidence-informed interventions:1) have been tested by at least one quasi-experimental design with a comparison group, with at least 10 participants; OR 2) have been adapted from evidence-based interventions.

Long-Term Services and Supports refers to a wide range of in-home, community-based, and institutional services and programs that are designed to help older adults and individuals with disabilities or chronic conditions with activities of daily living or instrumental activities of daily living.

No Wrong Door is an entry system where multiple agencies retain responsibility for their respective services while coordinating with each other to integrate access to those services through a single, standardized entry process that is administered and overseen by a coordinating entity. The goal of no wrong door is to create a system where social services wrap themselves around the individual and provide seamless access to information on available options.

Options Counseling is a person-centered, interactive, decision-support process whereby individuals receive assistance in their deliberations to make informed long-term support choices in the context of their own preferences, strengths, and values.

Essential components of Options Counseling include:

- a personal interview
- assisting with the identification of choices available (including personal, public, and private resources)
- facilitating a decision-support process (weighing pros/cons of various options)

- assisting as requested and directed by the individual in the development of an action plan
- connecting to services (when services are requested and assistance in connecting is requested or needed)
- follow-up

Options Counseling is available to persons regardless of their income or financial assets. Options Counseling is preferably provided by one person but may be collaboratively provided by more than one person or agency.

Person-centered Planning is planning that empowers people with disabilities by focusing on the desires and abilities of the individual. Person-centered Planning most importantly is directed by the individual but often involves a team of family members, friends, and professionals. The individual chooses their team members. This team then identifies the skills and abilities of the individual that can help them achieve their goals of competitive employment, independent living, continuing education, and full inclusion in the community. They also identify areas in which the individual may need assistance and support and decide how the team can meet those needs. While it is recognized that not all of the elements of a complete person-centered plan can be achieved prior to discharge from the hospital, many elements can be addressed. Elements, such as working with the consumer to develop the most independent living arrangement and providing assistance and supports that are desired by the consumer are included. The consumer with involvement of family members, professionals and others work toward the ultimate discharge plan goal of living as independently as possible with home and community-based services.

Program Eligibility Determination: A determination of the publicly supported benefits or services to which a person is eligible, based on non-financial criteria. This may require a formal assessment to determine the full scope of the individual's needs. It may include a functional assessment of the individual's current health conditions and provide a situational assessment of the client's environment, available resources, and current support. For Medicaid services, this function includes the "Level of Care" determination process.

Public Education and Outreach: Activities related to ensuring that all potential users of long-term support (and their families) are aware of both public and private long-term support options, as well as awareness of the ADRC, especially among underserved and hard-to-reach populations.

Single Entry Point (SEP) is a system that enables consumers to access long-term and supportive services through one agency or organization. In their broadest form, SEPs perform a range of activities that may include information and assistance, referral, initial screening, nursing facility preadmission screening, assessment of functional capacity and

service needs, care planning, service authorization, monitoring, and periodic reassessments. SEPs may also provide protective services. [3]

State: Refers to the definition provided under 45 CFR 74.2 any of the several States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, any territory or possession of the United States, or any agency or instrumentality of a State exclusive of local governments.

Self-direction is an approach to providing services (including programs, benefits, supports, and technology) intended to assist an individual so that:
(A) services (including the amount, duration, scope, provider, and location of the services are planned, budgeted, and purchased under the control of the individual;
(B) the individual is provided with the information and assistance necessary and appropriate to enable the individual to make informed decisions about the individual's care options;
(C) the needs, capabilities, and preferences of the individual with respect to services, and the individual's ability to direct and control the individual's receipt of services, are assessed by the area agency on aging (or other agency designated by the area a agency on aging) involved;
(D) based on the assessment made under subparagraph (C), the area agency on aging (or other agency designated by the area agency on aging) develops together with the individual and the individual's family, caregiver (as defined in paragraph (18)(B)), or legal representative:

- a plan of services for the individual that specifies which services the individual will be responsible for directing
- a determination of the role of family members (and others whose participation is sought by such individual) in providing services under the plan; and
- a budget for the services; and

(E) the area agency on aging or State agency provides for oversight of such individual's self-directed receipt of services, including steps to ensure the quality of services provided and the appropriate use of funds under this Act.

Senior, Older Adult as defined in the Older Americans Act, "an individual who is 60 years of age or older."

Statewide system is one in which individuals anywhere in the state have streamlined access to the full array of public and private sector programs and services that promote community living, health and independence

[3] Robert Mollica and Jennifer Gillespie, *Single Entry Point Systems: State Survey Results.* Rutgers/NASHP Community Living Exchange Collaborative, August, 2003.

Attachment H: Alzheimer's Disease Supportive Services Program Requirements

States must use Alzheimer's Disease Supportive Services Program (ADSSP) funds, provided under the Public Health Services Act, to implement dementia capable systems under this program announcement. The ADSSP has specific requirements that shape the use of funds:

- The statute governing the ADSSP program requires that grantees provide a 25% match (cash and/or in-kind) during the first year, 35% during the second year, and 45% during the third and subsequent years of the grant period. Waivers to these match requirements are not permitted under the Public Health Services Act.
- The statute governing the ADSSP program states, "the State agrees to expend not less than 50 percent of the federal grant funds for the provision of [direct] services" to persons with Alzheimer's disease or related dementias and their families.
- Those services which are listed as "direct services" in the program's statute are: "…home health care, personal care, [adult] day care, companion services, short-term care in health facilities, and other respite care to individuals with Alzheimer's disease or related disorders that are living in single family homes or congregate settings." For this program announcement, respite is defined as an interval of rest or relief **OR** the result of a direct service intervention that generates rest or relief for the person with dementia and/or their family caregiver. For example, if people with dementia and/or their family caregivers receive counseling or training through an intervention, the intervention will be considered to have generated respite for the participants. This may be considered part of the direct service requirement.
- States are not allowed to make payments with grant funds under this Announcement for any items or services to the extent that payment has been made, or can reasonably be expect to be made, with respect to such item or service under any State compensation program, under an insurance policy, or under any State or Federal health benefits program, such as Medicare and Medicaid, or an entity that provides health services on a prepaid basis.
- The statute governing the ADSSP program also states, "… the State agrees that not more than 10 percent of the grant will be expended for administrative expenses with respect to the grant."
- There are no age restrictions on who may be served through the ADSSP Program. Any person with Alzheimer's disease or a related dementia or their caregiver, regardless of age, is eligible for ADSSP services.
- In the ADSSP statute, there is a particular focus on providing access to services to individuals, "who are members of racial or ethnic minority groups, who have limited proficiency in speaking the English language, or who live in rural areas."

Attachment I: AoA-Sponsored Resource Centers

Alzheimer's Disease Supportive Service Program National Resource Center supports ADSSP grantees and their community partners' efforts to maintain integrated and sustainable service delivery systems for individuals with ADRD and their family caregivers. The ADSSP Resource Center maintains a web-portal with a variety of publicly-available resources that include: information about home and community-based interventions for people with dementia and their caregivers; physician outreach materials; publications about evidence-based caregiver interventions; and a comprehensive compendium of innovative practices. Visitors to the site are able to access information about ADSSP programs in their state, national and state-level data on persons served, web links to resources, and information on available funding opportunities. http://adrc-tae.org/tiki-index.php?page=AboutADSSP.

Evidence-based Health Promotion and Disease Prevention Program National Resource Center offers comprehensive information and technical assistance to State and community partners on a wide range of issues associated with the adoption, implementation, and expansion of evidence-based health promotion programs for the aging services network and community-based organizations serving older adults and younger people with disabilities. Technical Assistance includes a web site (http://www.healthyagingprograms.org) training materials (including online modules), webinars, fact sheets, policy briefs, an annual grantee meeting, and one-on-one technical assistance with AoA program officers through phone calls, emails and site visits.

National Resource Center for Participant-Directed Services (NRCPDS) serves to assist all programs, regardless of funding source, to develop and improve their participant-directed options. NRCPDS expertise is based in years of experience as the National Program office for the Cash and Counseling Demonstration and Evaluation project. NRCPDS' website - http://www.bc.edu/schools/gssw/nrcpds/ - provides information and resources on all aspects of consumer direction including webinars and training materials.

Technical Assistance Centers for Caregiver Programs and Lifespan Respite offer comprehensive information and training on a range of issues associated with the development and implementation of family caregiver support and Lifespan Respite Care Programs. Technical Assistance available includes two web sites (http://www.caregiver.org or http://www.archrespite.org) training materials, fact sheets, policy briefs, workshops, webinars, and specialized technical assistance through phone calls, emails and in-person communication.

Technical Assistance Exchange (TAE) makes information and resources available to states and community organizations that are designing, implementing or expanding Aging and Disability Resource Centers (ADRC) and other types of single entry point systems, to assist recipients of the Community Living Program (CLP) grants, Alzheimer's Disease Supportive Services (ADSSP) grants, and Veteran-Directed Home and Community Based Services Programs (VDHCBS). The assistance provided supports

program success and fosters a community of stakeholders involved in making changes to their long term care systems to exchange ideas, knowledge and best practices.

Attachment J: Programs and Initiatives

CDC—Community Transformation Grants,
http://www.cdc.gov/communitytransformation/

CMS Community Based Care Transition Program
https://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1239313&intNumPerPage=10

CMS **Multi-Payer Advance Primary Care Initiative**--
https://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1230016&intNumPerPage=10

CMS **Independence at Home Demonstration,**
https://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1240082&intNumPerPage=10

CMS Federally Qualified Health Centers Advanced Primary Care Practice Demonstration,
http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1230557&intNumPerPage=10

CMS **Money Follows the Person Initiative,**
http://www.cms.gov/CommunityServices/20_MFP.asp

CMS **Health Home for Enrollees with Chronic Conditions**,
http://www.cms.gov/SMDL/SMD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1241477&intNumPerPage=10

CMS ACO Pioneer Model, http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/pioneer-aco/

CMS Advance Payment Initiative Under Medicare Shared Savings Program,
http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/advance-payment/

CMS **State Demonstrations to Integrate Care for Dual Eligible Individuals,** http://innovations.cms.gov/areas-of-focus/seamless-and-coordinated-care-models/state-demonstrations-to-integrate-care-for-dual-eligible-individuals/

Resources and Initiatives:

HHS Partnership for Patients Initiative, http://innovations.cms.gov/areas-of-focus/patient-care-models/partnerships-for-patients/

HHS Initiative on Multiple Chronic Conditions, http://www.hhs.gov/ash/initiatives/mcc/

CMS Medicare-Medicaid Coordination Office- http://www.cms.gov/medicare-medicaid-coordination/

CMS Innovation Center, http://innovations.cms.gov/

HHS Public Health Quality Initiative, http://www.hhs.gov/ash/initiatives/quality/index.html

Attachment K: Fully Functioning Aging and Disability Resource Centers

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These criteria were developed to assist states measure and assess their progress toward developing fully functioning Single-Entry-Point/Aging and Disability Resource Centers (ADRCs). These criteria and recommended metrics are intended to be applicable across different types of ADRC models. The term "ADRC" in this document may be interpreted to represent one primary operating organization in each community, a network of organizations serving as operating partners in each community ("no wrong door" model), or a combination of state level and local level organizations operating in partnership. Metrics that should be interpreted differently or applied differently to systems with a single operating entity/single entry point or multiple operating partners/multiple entry points are noted.

The criteria can be viewed here: http://www.adrc-tae.org/tiki-download_file.php?fileId=29618